Guide for

HCFA's Rural Health Care Transition Grant Program

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Office of Research and Demonstrations

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U.S. Department of Health and Human Services
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CHAPTER 1

THE RURAL HEALTH CARE TRANSITION GRANT PROGRAM AND THE PURPOSE OF THIS GUIDE

CONGRESS ESTABLISHED THE GRANT PROGRAM

Congress introduced the Rural Health Care Transition Grant Program to improve the management and finances of small rural hospitals. As a result of financial problems in the 1980s, many rural hospitals had closed and others were struggling to stay open. The transition grant program was one of several federal initiatives developed to assure continued access to health care in rural America. Congress enacted the Grant Program for Rural Health Care Transition in 1987,[1] and subsequently modified it in 1989.[2]

The transition grant program is restricted to nonfederal, not-for-profit rural hospitals that have fewer than 100 beds. The grants are for up to 3 years, with maximum funding of $50,000 per year. The law specified only two restrictions on grant expenditures: Grants may not be used to retire debt incurred for capital expenses before the grant period, and the maximum expenditure on capital items is one-third of the grant amount.[3] The law stated the purpose of the program as follows:

> Each demonstration project . . . shall demonstrate methods of strengthening the financial and managerial capability of the hospital involved to provide necessary services. Such methods may include programs of cooperation with other health care providers, of diversification in services furnished (including the provision of home health services), of physician recruitment, and of improved management systems.

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[1]Omnibus Budget Reconciliation Act of 1987, Public Law 100-203, Section 4005 [e].

[2]Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, Section 6003 [g].

[3]Hospitals using the transition grants to convert to Rural Primary Care Hospitals are not subject to the one-third capital limitation.

The law specified seven problems the grant program was to address:

- Changes in clinical practice patterns
- Changes in populations being served
- Declining demand for acute care inpatient services
- Declining ability to staff inpatient hospitals appropriately
- Increasing demand for ambulatory and emergency services
- Increasing demand for integrated community health services
- Access to emergency care and inpatient care (including transportation) in areas where underutilized beds are being eliminated

Grants have been awarded to eligible hospitals every year since 1989. By now, nearly 400 grantees have completed their grant projects. They have opened or improved numerous patient services, recruited physicians, added community health education programs, conducted strategic planning and cooperated with other providers in consortia.

PURPOSE OF THE GUIDE

This guide is intended to assist rural hospitals in applying for grants and in implementing the types of changes envisaged by Congress when it introduced the transition grant program. Chapter 2 describes how to apply for a grant. Chapter 3 reviews some of the important issues in planning and implementing a project. Chapter 4 discusses grantee experience in implementing new services, and Chapter 5 examines grantee experience in implementing other types of projects. Chapter 6 illustrates grantee experience through several case studies of successful and

unsuccessful grant projects. Chapter 7 reviews the effects of the grant-supported projects on the hospitals and their communities. Appendix A summarizes grantee experience implementing different types of services. And, finally, Appendix B provides an annotated bibliography and lists sources of help. The guide was based on reports by 326 hospitals on their grant progress and on the findings of 98 case studies, during which evaluation staff visited or telephoned the hospitals and spoke with the hospital personnel who had implemented and operated the grant projects.

CHAPTER 2

APPLYING FOR A RURAL HEALTH CARE TRANSITION GRANT

This chapter reviews the process of applying for a transition grant. Most importantly, you should remember that the grants are awarded through a competitive process, not a political process, and that the quality of the application matters. Furthermore, the applications are judged by a set of published criteria that you, the applicant, should keep clearly in mind.

CHOOSING A GRANT PROJECT

Choosing a project wisely will improve your chances of receiving an award and increase the likelihood that the hospital can implement the project and benefit from it.

Well-chosen projects take into account (1) the *need* for the project (either a community need, such as a service that is not available, or a hospital need, such as computerizing billing functions), (2) the *feasibility of the project*--focusing especially on the *cost* of implementing it over and above the grant amount (for example, a new outpatient wing or a conversion of acute to skilled nursing beds would require funds beyond those available from the grant) and the *direct and indirect financial impacts of the project* on the hospital, and (3) the *support* for the project by management (including the board) and those who might be affected by its introduction (potential users, other providers).

Need

The project you choose must address a problem worthy of attack. This will depend on your circumstances and not necessarily those of other hospitals. As we discuss later, your application must describe the problem the project will address and make a clear case for why and how you will tackle it.

Feasibility

The project you choose must also be feasible, which requires that you can afford it and that it can be done.

Hospitals must conduct economic feasibility studies--not just needs assessments--either prior to, or as part of, grant activities, in order to ensure successful implementation of the proposed

programs or services. If a project should prove infeasible after study, the Health Care Financing Administration (HCFA) will usually allow the grantee to switch the grant funds to a different goal. It is better to make such a change than to waste money on fruitless efforts.

Because the grants are capped at $50,000 per year (and only one-third of the amount can be spent on capital items), grantees must also decide whether they can afford the total cost of the project. Don't be too optimistic about the time a service will require to break even or make money. (See Chapter 4 and Appendix A for details about how long it took grantees to implement services and whether the services were financially self-supporting after 3 years.) The transition grant should be viewed as seed money, not as a sufficient fund to implement a new service.

In addition, the experience of previous grantees may help you to decide whether your project is feasible (see Chapters 4, 5, 6, and Appendix A). For example, developing a continuum of geriatric services, including assisted living, sounds like a socially useful goal, but none of the grantees that set out to add assisted living has been successful so far (and only a minority of large hospitals offer assisted living). Nevertheless, if you are convinced of the importance of a goal that previous grantees have found difficult and you are sure you can afford it, do not be intimidated--the important thing is to learn from their experiences and mistakes.

Limit the number of goals to what can reasonably be implemented within 3 years. (Three years is the maximum length of a grant--you may also apply for a 1-year or 2-year grant.) After receiving an award, many grantees found they had too many goals and had to place some on hold or drop them. Fortunately, the grant program has been administered flexibly. If you need to modify your goals after receiving the award, HCFA will listen sympathetically to requests. More important than the number of goals is how well they are integrated with overall planning.

Support

Projects were most likely to be successful if they were selected from a strategic plan. If the hospital has a current strategic or short-term plan, selecting a grant project from the plan will have two advantages: (1) the project will already have the backing of the board and physicians; and (2) the plan will be likely to include needs assessments and feasibility studies, which will provide material necessary for writing the grant application. Hospitals without strategic plans should select projects that are likely to benefit the hospital and community. Don't forget that you may choose as a grant project to undertake planning and then implement goals identified through the planning process. If you do propose a two-stage planning and implementation grant project, you should illustrate with one or two examples how you would implement activities identified during planning, to show that you understand how such activities must be managed.

Applicants used a variety of approaches to select their grant project goals. Some chose projects identified by a prior planning process (including community studies to establish need). Others delegated the choice of project to senior executives or assembled a committee of interested parties to generate ideas. About one-third of the case study grantees reported selecting ad hoc projects that were initiated essentially because the grants were available.

THE GRANT APPLICATION

The application must be prepared according to HCFA instructions. *Follow the instructions in the grant application packet!* Correctly prepared applications make it easier for the review panels to assess the relative merit of the applications. You should also:

- Check whether you are eligible before applying.
- Provide the information requested.
- Provide the information in the format requested.

- Do not exceed the length limit. (In the past, it has been 25 pages.)

When you have drafted the application, ask someone who has not been involved in writing it to review it. Ask your reviewer if he or she can understand what you are proposing to do and why you are proposing to do it. If the reviewer can't understand what you are saying, then neither will the review panel.

Preparing the Application Narrative

The application narrative has five sections. The reviewers score each section up to a certain number of points, and the total possible score for all sections is 100. Reviewers respond better to prose that is organized well and written in simple, straightforward language. (See McCarthy, 1978, for a description of how to apply for a grant.[1]) Start by preparing an outline that incorporates all the information requested. Each paragraph should deal with a single topic. Write short sentences rather than long wandering ones. Avoid jargon. Develop concepts in logical order.

Describing the Project Goal. [*Up to 20 points are awarded for this section of the grant application.*] Write a clear statement of the purpose of the proposed project. The statement must describe the problem that the project will address and provide statistical and descriptive area data illustrating the problem. For example, if the problem involves overcoming the area's shortage of physicians, the grant application should describe the number and types of physicians in the area, the population--size, social and economic characteristics, and distribution in different towns--and access problems (such as travel times to the nearest physician or wait times to an appointment) the population faces in the absence of sufficient physicians. Maps are a good way to illustrate remoteness and access problems. Remember to relate

[1]McCarthy, J.T., J.C. Bauer, and R.L. Call. "Successful Grantsmanship." *Health Care Management Review* vol. 3, no. 37, Summer 1978.

the grant project purpose to the Congressional intent (see Chapter 1).

Describing the Project. *[Up to 30 points are awarded for this section of the grant application.]* This section carries the most points. In it, explain what you will do and how you will do it. Describe the steps to achieving the goal, when they will take place, and who will be responsible for making sure each step is completed. Having a project coordinator other than the administrator sometimes helps to keep you on schedule later. Don't be too optimistic when developing your schedules.

Impact on Access for Medicare Beneficiaries. *[Up to 20 points are awarded for this section of the grant application.]* Describe how the project will directly or indirectly improve access for Medicare beneficiaries. Direct access improvements may result from offering new services or recruiting additional health professionals. Indirect access improvements may result from projects that improve the financial status or the management of the facility, thus keeping it viable as a service provider.

Coordination. *[Up to 20 points are awarded for this section of the grant application.]* Discuss the support you have organized for this project from other health care providers and the community. The review panels are looking for tangible support (coordination plans, cash, or in-kind contributions) from these sources, in addition to letters from local health care providers and community leaders supporting the project.

Impact on Medicare Expenditures. *[Up to 10 points are awarded for this section of the grant application.]* This is perhaps the most difficult part of the grant application. You must estimate how much money your project will save the Medicare Trust Funds. This requires you to develop assumptions about changes in service use and the associated costs. If you are introducing a primary or secondary prevention program for elders, or you are recruiting an additional internist, for example, you might document the expected reduction in the number of hospital stays as a result of improved fitness and improved primary care.

You could estimate the number of avoided hospital stays for elderly patients by determining how many Medicare patients you admit annually and estimating a realistic percentage reduction in stays from a fitness program or improved primary care (use published information on such impacts if possible--see the resources listed in Chapter 8 if your health professionals do not know of a source). The impact on Medicare costs would be the average payment per Medicare stay, multiplied by the estimated number of avoided hospital stays. If you are introducing a new outpatient service, you might document the reduced cost of providing the service on an outpatient rather than an inpatient basis. Include in the application the assumptions that you used to make your estimate.

Other Sections of the Grant Application

In addition to the narrative, prepare a budget, by year, and describe the persons who will be responsible for running the project. You must also provide several other certifications and assurances. Again, follow the instructions in your packet.

Getting Help

You can write your own grant application--a consultant is not necessary and will not guarantee success. Most past applicants wrote their own grant applications rather than hiring consultants to do so. Successful grant application writers have included administrators, senior managers, physicians, nurses, allied health professional staff, board members, and staff in a multihospital system of which the hospital is part. In some states, offices of rural health and state hospital associations have been helpful in providing background information.

Unsuccessful Applications

Unsuccessful applications are those that receive low marks. Reviewers give low marks when they cannot understand what applicants plan to do, when applicants do not make a convincing case for their project, and when applicants have unrealistic goals and schedules. Applications that do not explain exactly what the grant project will involve (for example an application that proposes to develop a strategic plan but does not explain the steps: board meeting, consultation, community interviews, and so forth) will receive lower marks than one that explains how the

project will be implemented. An application that includes many letters from community leaders saying the project is important but does not provide the reasons why it is important will receive lower marks than an application that provides the reasons. For example, if the project is to implement a satellite Rural Health Clinic, you should explain the community's access problems--such as lack of physicians in the community, lack of public transportation to reach towns where there are physicians, and so on. Applications that have too many unrelated goals or that propose to add services requiring a lot of hospital financing, without explaining the source of financing, may be perceived as unrealistic. Detailed budgets and management plans with timetables and responsibilities are more convincing to reviewers.

GRANTEE SELECTION PROCESS

Once you have submitted your grant application, it is subject to a review process. Understanding how that process works may help you to write a successful grant application.

Application Review

After the grant applications are received, they are grouped and sent to panels of reviewers. The reviewers read and discuss the grant applications and then score them according to the criteria for award (maximum score is 100). They also indicate whether they believe a grant application is too weak to be acceptable. Only applications considered acceptable by the reviewers may be awarded a grant. A consortium of two or more hospitals receives one score for the whole consortium and is treated as one applicant in the selection process.

Selection

Grantees are selected in a two-stage process that ensures geographic dispersion of the grants. First, the total grant funds available are assigned to the states according to the proportion of the nation's eligible rural hospitals located in each state. The applications are ranked by state, and the top-ranking grant applications in each state are picked, up to the limit of the funds assigned to that state. Second, any remaining funds are pooled. Then the grantees not picked in the first stage are ranked by

score, regardless of state, and the top-ranked grantees are picked, up to the limit of the remaining funds. (Although HCFA reserves the right to select grantees on the basis of project goal rather than score, it has not done so in the past.)

Grant Awards

Once the grantees have been selected, announcements are made by September 30, the end of the federal government's fiscal year.

CHAPTER 3

PLANNING AND IMPLEMENTING GRANT PROJECTS

Congress, in setting up the Rural Health Care Transition Grant Program, intended the grant projects to improve the management and finances of the rural hospital grantees. To have this effect, grant-funded projects must be selected, planned, and implemented with care. This chapter discusses factors in successful project implementation. First, we discuss the role of strategic and project planning. We then examine strategies to improve the likelihood of project implementation.

STRATEGIC PLANNING: A FACTOR IN SUCCESS

Failure to plan properly is an underlying factor in both poor hospital performance and poor grant project performance. To assist applicants for transition grants, this section discusses key components of strategic planning and the planning that should be part of all grant projects.

Strategic planning is nothing more than anticipating the future and figuring out how to get there.[1] The process is *strategic* because it challenges underlying assumptions about an institution's needs, programs, funding, costs, and competitors. Strategic planning helps board and staff work toward common goals and facilitates effective management. Indeed, a properly executed strategic planning process is an excellent management tool because it produces a clear and consistent set of directions for getting important things done. The strategic plan is like a pilot's flight plan--and pilots are not wise to fly without one. It provides a description of the tasks to be accomplished, assigns responsibility for managing the tasks, sets dates for project commencement and completion, and identifies the amount and sources of funds necessary to do the work. Its product is a set of institutional goals and priorities, both long term and short

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[1]Formally, strategic planning is "the collective set of actions that afford an organization a good shot at a competitive advantage that is sustainable for a period of time" (from "Frequently Asked Questions About Strategic Planning" by Arthur B. Raybin & Associates, article from this consulting firm's newsletter, reprinted in *Community Jobs*, March 1994).

term, shared by the organization's stakeholders (for example, governing board, employees, medical staff, and so on). A good strategic plan is also closely linked with marketing activities and project evaluation. Once considered the domain of staff specialists (health planners), strategic planning is now widely considered to be an important function of top-level executives.

Strategic planning can be an *internal* process, or the hospital can use planning *consultants*. When it is an internal process, a planning committee can assume much of the responsibility for shaping the strategy. Consultants can either conduct the strategic planning process for the hospital or assume a coordinating role--teaching management and staff about the process and building planning skills within the hospital. Consultants with successful rural hospital experience are a valuable resource.

The board and chief executive officer ultimately need to make the *decision to initiate* strategic planning. The ideal strategic planning process includes the participation of all who contribute to the organization: the board, management, departmental staff, key volunteers, program and service recipients, even donors. Top management provides the leadership to inspire and motivate the organization to change.

Needs Assessment

The first component of strategic planning is needs assessment. Hospitals assess the needs of their community by documenting the health status and composition of the population (age, sex, occupation). On the basis of this information, they then forecast demand for different types of services. The process can include *focus groups*, *surveys*, and an internal *review of referrals*.

Useful information about referral patterns can usually be gained from individual or focus group discussions with local physicians who refer patients elsewhere for clinical consultations. (If local primary care physicians might be bypassing local specialists, private and confidential discussions will produce more useful information.) Local doctors will not normally have complete information about the nature and extent of patient self-referrals to physicians in other communities, however. This important

information can often be obtained from the benefits administrators of larger local employers that provide good health insurance for their employees (such as school districts, county and municipal governments, public utility companies, manufacturers, and so on).

Feasibility Assessment

The second element of strategic planning, feasibility assessment, allows a hospital to determine whether it has and can expend the *resources necessary to implement and maintain* a program or service and what *benefits* (monetary or otherwise) the institution will derive from implementation.

To estimate economic feasibility the hospital must first assess the implementation and maintenance requirements for the program or service in question: (1) *capital* requirements, such as space renovation and/or construction, equipment purchases, and financing; (2) *labor* requirements, including staff numbers and qualifications as well as training; and (3) *other resource* requirements, such as coordination with other providers and subsidization of the program once implemented. The hospital must then consider whether the service is already available in the community and its likely reimbursement rates from different payers. *Institutional factors*, such as the likelihood of obtaining a Certificate of Need or Medicare certification (if required), recruiting a specialized health professional, or encountering opposition from other local providers, are also taken into consideration as a part of feasibility assessment. For example, grantees that implemented Rural Health Clinics without feasibility studies sometimes had delays and encountered reimbursement difficulties because they were unable to meet Medicare requirements. One grantee never implemented its ventilator unit because it was unable to get cost-based Medicaid reimbursement.

The economic feasibility study should recognize the grant program's *limitation on capital expenditures*. If the project involves extensive construction and renovation or requires some renovation and expensive equipment purchases, the hospital must have available (or make provisions to obtain) the resources to cover capital expenditures in excess of one-third of the grant

award. Some grantees had to delay implementation of projects such as outpatient surgery because of their inability to raise the additional funds.

Hospitals must also *estimate the benefits* from proposed projects. Financial benefits can be direct (for example, if the service introduced is a net revenue producer) or indirect (for example, if the new program or service increases utilization of other hospital services). Once implemented, projects such as adult day care and mobile health clinics were used less often than expected, and program costs exceeded revenues. Experience also suggests that nonemergency transportation, community education, social services, wellness, and Lifeline™ programs normally must be subsidized. The hospital must consider whether it can afford to continue the subsidy after the grant has ended--and the potential loss of goodwill if it drops such a program.

Environmental Assessment

The final element of strategic planning is environmental assessment. At this stage, the hospital identifies and evaluates likely changes in its finances, community, competition, and regulatory environments (at the local, state, and national levels), determines its options, and selects the most appropriate course of action in response to each scenario.

PLANNING AND IMPLEMENTING A PROJECT

This guide is intended to alert rural hospitals to pitfalls to be avoided and sources to help them plan and implement new projects. Strategies to keep in mind during project planning and implementation are developing a management plan, using project coordinators and consultants, gathering data, coordinating efforts with physicians, and coordinating efforts with other providers. Remember that grants are awarded with conditions attached--you must comply with these conditions to be assured of continued funding.

Management Planning

The first step in project planning is to develop a management plan. A management plan should (1) *identify tasks and subtasks* required for implementation, (2) develop a *budget* and a task-specific *schedule* for project implementation, and (3) assign *responsibilities* for each task. Successful grant applications normally contain such a plan--but the management plan may need to be reviewed and revised after the grant is received. Regular review of progress relative to the plan will help to keep the project on target.

A Project Coordinator

A project coordinator may help with project planning and implementation. Case study grantees often commented that having a project coordinator had helped them to implement their projects. When hospitalwide crises developed (mainly because of the departure of physicians or top managers), project coordinators were better able than hospital administrators to maintain their focus on project implementation. Furthermore, assigning the coordinator role to a staff member other than the administrator provided opportunities for developing the skills of mid-level managers, which many hospitals found valuable. In selecting a project coordinator, consider (1) using an existing staff member (many grantees got behind in their original schedules early in the project because they had to recruit a project coordinator); (2) the individual's ability to work with board members, managers, physicians, and nonphysician staff to garner their support and cooperation for the project; and (3) the individual's ability to work with regulatory agencies and other providers. Grantees in consortia sometimes had a single coordinator for the entire group.

Consultants

Consultants provide specialized information that can help you implement management and service projects. Grantees used consultants in management projects such as strategic planning, utilization review, and fundraising. They also used consultants effectively to recruit physicians and to establish services such as Rural Health Clinics. To avoid wasting grant money, choose a consultant who (1) is familiar with the local regulatory environment, with programmatic requirements, and with the special requirements of rural hospitals; and (2) has already

successfully implemented the service at similar institutions in your state.

Data Gathering

You may also gather information in other ways, such as from other hospitals and by going to seminars. Sending staff to visit an operational program in your state of the type you plan to implement can be a successful planning strategy. Those who have been through the process can help you to avoid their mistakes. You may also be able to send staff to seminars on specialized topics. For example, one consortium sent its staff to a course on how to set up a cardiac rehabilitation program, which gave them the information and confidence they needed to implement the program.

Coordinating with Physicians

Coordinating with physicians is also an essential element of implementing services. Physicians must be part of project selection, planning, and implementation. Physicians can play many roles in grant projects. As medical directors of new services, they are responsible for quality assurance and supervision of clinical staff. They may also refer or admit patients to the new service. Project coordinators must work constantly with members of the medical staff to address their concerns and to ensure physicians' support to the maximum extent possible.

Cooperating with Other Providers

Cooperating and coordinating with other providers during the planning stage may also be an effective strategy to achieve project goals and successful implementation. For example, by coordinating with other local providers and obtaining their support for grant projects, some grantees who experienced problems might have been able to avoid conflict (litigation in the worst case) that delayed project implementation.

Don't rush into implementation before you have completed project planning--including assessing feasibility, if this has not already been done. When asked if they would do anything differently if they had to do it over, 12 percent of the grantees said they would plan more thoroughly, and 30 percent said they would spend more time on the project.

CHAPTER 4

LESSONS LEARNED: GRANT-FUNDED SERVICES IMPLEMENTED

Evaluation of the grantees' experiences with new services leads to the conclusion that there is no model grant project. Grantees implemented a large number of services and planned to keep most of them, whether or not the services were financially self-supporting.

This chapter provides information about the experiences of grantees attempting to implement a range of service projects. The examples provided are based on semi-annual progress reports from 326 of the grantees and from site visits and telephone contacts with 98 case study grantees (selected from the 326). The case studies should provide lessons on successes and failures for the benefit of other hospitals. Success means first that the grantees implemented the projects, and second that the implemented projects enhanced community access or hospital finances.

AFTER THE GRANT ENDS

Hospitals are likely to abandon implemented grant projects that do not improve either community access or hospital finances. Abandoned projects waste valuable resources that could have done some good if put to more productive use. The grantees' most common reason for dropping new programs after the grant period was the inability to subsidize programs that did not cover their own costs. To ensure project continuation, hospitals must establish strategies for developing and maintaining service use, maximizing reimbursement, and subsidizing services that can never be financially self-supporting.

Once implemented, some services had lower-than-expected utilization rates. Grantees attributed this to (1) the local community not being accustomed to the availability of the service, (2) hesitation on the part of physicians and other providers to refer patients to the new service, and (3) lack of reimbursement discouraging potential users. Grantees overcame lack of information by actively publicizing services (for example, through articles in the local newspaper, radio spots, and community newsletters) and surmounted physician resistance by

coordinating with physicians and other professionals to increase referrals. Even when services such as primary care clinics and home health programs encountered difficulties in building their caseloads, most case study grantees believed that these services had the potential to achieve break-even performance or become profitable within a short period of time (that is, 6 months to a year after the grant's end). In such cases, project planning should include provisions for subsidies until a service becomes self-supporting.

Some grant projects did not cover costs because reimbursement was absent or lower than expected. Sometimes a hospital did not get reimbursed because its billing procedures were inadequate and could and should have been improved. Sometimes staff lacked knowledge of insurance requirements and did not submit adequate documentation. Two strategies grantees found helpful for reducing the number of denied claims were (1) sending staff to workshops to learn about billing requirements, and (2) allocating billing for a service to only one or two staff members, who developed expertise in getting reimbursement in the area.

Some grantees implemented Medicare-certified inpatient units expecting to receive an enhanced level of reimbursement, only to find out during the first year of operation that they did not receive the enhanced reimbursement (for example, an inpatient psychiatric unit sought exemption from prospective payment and a transitional care unit sought cost-based reimbursement). Be prepared to operate for a period without the enhanced reimbursement you are seeking. Check your state's history of certifying units as exempt from Medicare's prospective payment system. Another problem grantees encountered was little or no reimbursement for some services--especially mental health and ventilator units. An economic feasibility study can indicate whether a service will be able to cover costs at current reimbursement levels.

Other projects, such as community health education, routine medical transportation, and Lifeline™, may never pay for themselves directly. These programs are generally introduced not to produce revenue, but rather as a service to the

community. The benefits of implementing such services tend to be indirect or nonmonetary. For example, providing routine medical transportation can increase use of other hospital services, such as cardiac rehabilitation, primary care clinics, and outpatient mental health clinics, and thus increase hospital revenues from those services. By improving the public's awareness of health issues and of services available within a hospital, health education can improve the community's health status and enhance the hospital's reputation which, in turn, may encourage greater utilization. In other cases, such as emergency room services, the hospital's board and staff may conclude that, although not financially self-supporting, the services are indispensable. Planning for these services should include provisions for subsidizing the program on a permanent basis.

Projects like the conversion of acute care beds to nursing home services appeared to have a positive financial impact on grantees, but also required large capital and human resource investments before and during the grant period. For example, because a majority of grantee hospitals were built 20 or more years ago, space-planning studies for the conversion of acute care beds to skilled nursing beds--done as a part of feasibility assessment--often showed that extensive renovation or new construction would be desirable or required. Because of the high cost of renovation or new construction, these projects were more likely to be implemented by hospitals with greater financial resources (such as larger rural hospitals).

These observations are not intended to discourage you from undertaking any one of these projects. You would be wise, however, to learn from the experiences of past grantees and to plan to address the problems that they encountered.

WHICH WERE THE PROBLEM PROJECTS?

Some types of projects were relatively unsuccessful. The first measure of lack of success was that a low proportion of grantees actually implemented the project, despite their intentions. Half or less of the grantees intending to implement the following services actually did so: assisted living, primary care clinics, emergency medical transportation, adult day care, home health and hospice services, inpatient mental health services and ventilator units. Even so quite a few hospitals did implement these services (excepting assisted living and ventilator units).

TABLE 1

SERVICES WITH IMPLEMENTATION RATES OF 50 PERCENT OR LOWER

Service	Implementation Rate	Number Successfully Implemented
Assisted Living	0 %	0
Primary Care Clinics	36 %	38
Emergency Medical Transportation	40 %	18
Adult Day Care	43 %	12
Home Health and Hospice Services	50 %	61
Inpatient Mental Health Services	50 %	11
Ventilator Unit	50 %	2 [a]

[a]Two grantees implemented a ventilator unit between 1989 and 1992 but neither of the two grantees proposing to implement one between 1990 and 1993 was successful.

Additional measures of success are whether the projects were financially self-supporting at the end of the grant period and whether the hospitals will keep the services after the grant is over.

TABLE 2

SERVICES LEAST LIKELY TO BE FINANCIALLY SELF-SUPPORTING

Service	Percent of Projects Financially Self-Supporting
Routine Medical Transportation	16 %
Community and Patient Education	25 %
Adult Day Care	46 %
Lifeline™	46 %
Ventilator Unit	50 %
Social Services and Outreach	50 %
Wellness and Fitness	51 %
Mobile Health Clinics	57 %
Rural Health Clinic	58 %
Oncology and Chemotherapy	58 %

Nevertheless, most grantees planned to keep the services after the grant was over. The only services to be discontinued were:

TABLE 3

SERVICES TO BE DISCONTINUED

Service	Discontinuation Rate
Lifeline™	15 %
Wellness Programs	12 %
Routine Medical Transportation	10 %
Adult Day Care	10 %
Patient and Community Education	9 %
Mobile Health Clinics	9 %
Emergency Medical Transportation	8 %
Inpatient Mental Health Services	6 %

NEW SERVICES

The following discussion of grantee experiences is organized into three sections: (1) Outpatient Clinics and Emergency Services; (2) Inpatient Services; and (3) Community, Preventive, Transportation, and Diagnostic Services. Summaries of grantee experiences with each type of service are in Appendix A.

Outpatient and Emergency Services

Services Implemented. Adding an outpatient or emergency service was one of the most popular grantee goals. Most of the grantees setting out to add or upgrade these services were able to do so, and most of the services were paying for themselves by the end of the grant period. Not surprisingly, grantees planned to continue all outpatient and emergency services after the grants ended. Table 4 shows how many grantees implemented these services.

The top five services grantees opened or upgraded were outpatient surgery, emergency room services, Rural Health

TABLE 4

NUMBER OF GRANT-FUNDED OUTPATIENT AND EMERGENCY SERVICES IMPLEMENTED

Service	Grantees Implementing the Service		Implementation Rate[a] (Percentage)
	Number	Percentage of All Grantees	
Outpatient Surgery	55	17	57
Emergency Room	55	17	67
Rural Health Clinics	48	15	90
Physical Therapy	48	15	60
Cardiac Rehabilitation and Cardiac Clinics	41	13	88
Primary Care Clinics	38	12	36
Unspecified Specialty Clinics	18	5	61
Oncology and Chemotherapy	17	6	100
Occupational Therapy	16	5	100
Mental Health	15	5	57
Ear, Nose, and Throat Clinics	15	5	NA
Mobile Health Clinics	12	4	100
Grantees Reporting	326	--	--

NOTE: Data are for both 1989 and 1990 grantees, except that the implementation rate is for the 1990 grantees only.

[a]The implementation rate is the number of 1990 grantees implementing a program or service that originally proposed it as a grant goal, divided by the total number of grantees that proposed implementing it. This last number can be less than the number of grantees actually implementing, because grantees have flexibility in deciding which projects to implement after being awarded a grant (that is, based on needs assessment and/or feasibility studies done with grant support).

Clinics (those established under Public Law 95-210), physical therapy, and cardiac rehabilitation and cardiac clinics. These are exactly the types of ambulatory services Congress expected rural hospitals to add to maintain access and diversify services.

Some services were easier to implement than others. Occupational therapy, oncology and chemotherapy clinics, mobile health clinics, Rural Health Clinics, and cardiac clinics had the highest implementation rate: 88 to 100 percent. (The implementation rate is the percentage of hospitals proposing the service in their grant application that actually implemented it.)

Grantees had the least success in implementing primary care clinics (other than Rural Health Clinics). The implementation rate for primary care clinics was only 36 percent. Outpatient surgery and mental health clinics also had relatively low implementation rates.

Difficulties Implementing Services. The services with the lowest implementation rates, such as primary care clinics and outpatient surgery centers, had difficulties recruiting physicians or visiting specialists, which delayed or prevented the services from opening. Hospitals implementing emergency room and physical therapy services often fell behind schedule because of difficulties recruiting nurse practitioners, physician assistants, and physical therapists. Strategies for successful recruiting are addressed in Chapter 5.

Compliance with regulations was an important factor in the successful implementation of Rural Health Clinics and outpatient surgery. Some grantees implementing Rural Health Clinics said that understanding and meeting Medicare regulations was difficult. Using consultants who had established Rural Health Clinics and were familiar with certification requirements in the state was mentioned as a factor that contributed to speedy implementation. Two grantees that proposed adding outpatient surgery were not licensed as general hospitals by their states and had to drop the goal. Remember, you must always meet both Medicare *and* state requirements, and they are often different.

Difficulties After Implementation. After implementing outpatient surgery programs, mobile health clinics, Rural Health Clinics, and other primary care clinics, some grantees found use to be lower than expected and had difficulties covering costs. They might have predicted these problems by estimating patient volume in a feasibility assessment and averted them through publicity and through encouraging providers to refer patients to the service.

Physicians can have a great impact on the use of a service, referrals, and supervisory relations. Projects such as cardiac rehabilitation and outpatient chemotherapy had difficulty building their initial caseloads when local physicians were hesitant or unwilling to refer patients to the new service. There were also instances in which the success of Rural Health Clinics was jeopardized because physicians were unwilling to work with, or delegate responsibility to, mid-level professionals. Successful programs dedicated staff resources to maintaining frequent and effective contacts with physicians. With regard to mobile health clinics, many grantees found the service unsatisfactory once implemented. In addition to low utilization, mobile units required frequent repairs that made them unreliable. (See Case Study 4 in Chapter 6.)

Inpatient Services

Services Implemented. Fewer than 20 percent of grantees implemented inpatient services with their grants. Hospitals most often implemented swing beds and skilled nursing units. Once implemented, a large proportion of the inpatient projects (96 percent among 1990 grantees) were financially self-supporting by the end of the grant period. All grantees implementing inpatient services said the services would continue after the grants ended. Table 5 shows how many grantees implemented inpatient projects.

Most grantees implementing inpatient services converted acute care beds to beds with lower levels of acuity (such as skilled nursing, transitional care, or swing beds). Some established psychiatric and substance abuse units. Others proposed to develop a continuum of services that reached beyond the hospital's traditional role, into posthospital care. For example,

some hospitals planned assisted living programs because they already had swing beds, skilled nursing units, or both.

Difficulties Implementing Services. Inpatient service projects often took longer to plan and implement than originally expected. Careful preparation for implementation had important benefits, however. *Planning* helped determine that, for example, jointly staffing a psychiatric unit with an existing chemical dependency unit would be more efficient than separate staffing, and that 20 beds for a transitional care unit would be more cost effective than 9, thus lowering costs for the hospitals. *Feasibility studies* for projects such as assisted living and skilled nursing units steered some grantees away from these goals by forecasting insufficient demand for the service, which could jeopardize the hospitals' long-term financial viability. Grantees said that *consultants* were helpful in making these project planning determinations.

The majority of inpatient projects involved opening new patient units. Both the *financing* for the projects and the *required construction or renovation* made these projects vulnerable to implementation delays. For example, none of the grantees proposing to add assisted living services did so within the grant period, mostly because of difficulties in obtaining construction financing. Perhaps because of the large amount of coordination required, successful grantees mentioned *having a project coordinator* as a factor that accelerated implementation of their inpatient programs.

Grantees encountered various types of implementation problems. Obtaining the *Certificate of Need* required by some states was often a stumbling block for grantees proposing to establish

TABLE 5

NUMBER OF GRANT-FUNDED INPATIENT SERVICES IMPLEMENTED

Service	Grantees Implementing the Service		Implementation Rate[a] (Percentage)
	Number	Percentage of All Grantees	
Swing Beds	23	7	75
Nursing Homes, Skilled Nursing Units, and Transitional Care Units	21	6	82
Mental Health and Substance Abuse	11	3	50
Inpatient Surgery	5	2	100
Ventilator Unit	2	<1	0 [b]
Comprehensive Rehabilitation	1	--	NA
Inpatient Case Management	1	--	NA
Grantees Reporting	326	--	--

NOTE: Data are for both 1989 and 1990 grantees, except that the implementation rate is for the 1990 grantees only.

[a]The implementation rate is the number of 1990 grantees implementing a program or service that originally proposed it as a grant goal, divided by the total number of grantees that proposed implementing it. This last number can be less than the number of grantees actually implementing, because grantees have flexibility in deciding which projects to implement after being awarded a grant (that is, based on needs assessment and/or feasibility studies done with grant support).

[b]Neither of the 1990 grantees planning to implement ventilator units was successful. Two 1989 grantees were able to implement ventilator units.

NA = not available.

nursing home and skilled nursing units. Opposition from other providers (such as local nursing homes) occasionally culminated in lengthy litigation, which significantly delayed implementation.

Difficulties with surgeon recruitment delayed the implementation of some inpatient surgery programs.

Difficulties After Implementation. Once programs had been implemented, some grantees had *difficulties with Medicare or Medicaid reimbursement*, for example, transitional care units, swing beds, and ventilator units. One grantee weathered the problem by subsidizing the service during its first year. As discussed in Chapter 3, a feasibility assessment might have shown that these project choices were poor ones for these hospitals.

Community, Preventive, Transportation, and Diagnostic Services

Grantees implemented a variety of outreach programs and medical services outside the hospital to increase their revenues, meet community needs, improve community health status, and promote the hospital. Table 6 shows how many grantees implemented preventive, community, diagnostic, and transportation projects.

Community Medical and Social Services. Hospital-based home health programs are generally considered to be good revenue producers for hospitals. Grantees that successfully implemented home health projects reported them to be well utilized and financially beneficial. Grantees unable to implement their proposed home health programs noted difficulties in recruiting registered nurses or competition from agencies opened by other providers.

Case management and discharge planning programs help ensure that discharged patients receive the services they need, thus reducing repeat hospitalizations. Grantees had much success with these projects. Fifteen percent implemented case management and related social service projects; three-quarters proposing to implement this type of project succeeded in doing so. According to one successful grantee, case management helped the hospital cut costs by reducing average length of

TABLE 6

NUMBER OF GRANT-FUNDED PREVENTIVE, COMMUNITY MEDICAL AND SOCIAL, TRANSPORTATION, AND DIAGNOSTIC SERVICES IMPLEMENTED

Service	Grantees Implementing the Service		Implementation Rate[a] (Percentage)
	Number	Percentage of All Grantees	
Preventive Services			
Community health education	100	31	76
Wellness programs	41	13	55
Lifeline™	15	8 [b]	67
Community Medical and Social Services			
Home health/hospice	61	19	50
Social services	49	15	72
Adult day care	12	4	43
Transportation			
Routine medical	36	11	67
Emergency	18	6	40
Diagnostic			
Mammography	25	8	50
Other diagnostic	37	19 [b]	80
Grantees Reporting	326	--	--

NOTE: Data are for both 1989 and 1990 grantees, except that the implementation rate is for the 1990 grantees only.

[a]The implementation rate is the number of 1990 grantees implementing a program or service that originally proposed it as a grant goal, divided by the total number of grantees that proposed implementing it. This last number can be less than the number of grantees actually implementing, because grantees have flexibility in deciding which projects to implement after being awarded a grant (that is, based on needs assessment and/or feasibility studies done with grant support).

[b]Shown as a percentage of the 1990 grantees only, because these data are not available for 1989 grantees.

NA = not available.

inpatient stays, while maintaining needed services. (See Case Study 1 in Chapter 6.)

The majority of grantees implementing adult day care programs had disappointing experiences. Service utilization was often much lower than expected. Consequently, many grantees had difficulties covering program costs.

Preventive Services. Wellness and community health education programs can help improve a community's health status, while increasing awareness and use of a hospital and sometimes even helping the hospital maintain or improve its market share. Community and patient health education programs were the most popular grantee goal. Education programs took a variety of forms, including seminars on health topics, health screenings, health fairs, and newsletters. Although these services were easy to implement and popular with their communities, about 10 percent of grantees planned to discontinue them after grant support ended because they did not generate enough revenue to be self-supporting.

Transportation. Lack of transportation is a severe problem in rural areas. Routine medical transportation is consequently seen as meeting a community need. The grantees created or expanded 36 routine medical transportation programs. Successful grantees noted that bringing in patients who otherwise would not have used their services improved the community's health status and the financial viability of ambulatory services in their hospitals. Another benefit cited was improved physician efficiency, as fewer patients missed appointments.

Many rural hospitals exist primarily because area residents want (and need) emergency services. Yet the grantees had limited success with emergency transportation projects. Among 1990 grantees, the implementation rate for these projects was 40 percent. One case study grantee reported serious difficulties with retaining trained emergency medical technicians. (See Case Study 5 in Chapter 6.)

CHAPTER 5

LESSONS LEARNED: GRANT-FUNDED RECRUITING, MANAGEMENT, AND OTHER PROJECTS

This chapter describes grant-supported activities other than service implementation. These activities include physician recruiting, planning and management projects, staff training, and a variety of projects introduced by grantees in consortia. The examples are based on semi-annual progress reports from 326 of the grantees and from site visits and telephone contacts with 98 case study grantees (selected from the 326).

RECRUITING PHYSICIANS

Most hospitals, both rural and urban, are recruiting physicians, most of the time. Although only 30 percent of the grantees proposed to recruit physicians with grant funding, more than half ended up using their grants to do so. This increase in grant-funded recruiting resulted from physician turnover during the grant period; hospitals that started out with an adequate number of physicians lost some or all of them, and some nearly closed.

To flourish, rural hospitals require physicians to admit patients or refer them to outpatient services. The grantees started recruiting physicians when they expected losses (as a result of retirements and planned departures), when they experienced sudden, unexpected losses (such as deaths or unannounced departures), and when difficulties in cooperating with existing physicians compelled hospitals to start their own clinics.

Some of the reasons that grantees lost physicians may also make recruiting more difficult. These reasons include professional factors, such as few colleagues, lack of adequate equipment in a hospital, and conflicts with other physicians, as well as social factors, such as remoteness of an area, lack of amenities found in larger towns, and lack of enthusiasm for an area by a physician recruit's spouse.

Problems Encountered. Physician recruitment often demanded more time and money than grantees expected. Some had difficulty recruiting because local physicians did not cooperate. For example, some physicians undermined recruitment efforts by telling recruits that the area could not support more physicians.

Some others would not network with colleagues to help identify potential candidates. Retiring physicians did not always recognize how long finding a replacement can take and discouraged the hospital from recruiting until the time of their retirement.

For grant-recruited physicians to have lasting impacts on their hospitals and communities, they must build practices in the communities and remain in the area. By the end of the 3-year grant period, 17 of the 143 physicians recruited with the grants had already left the grantee areas.

Solutions. Recruiting is simplest when local physicians cooperate and the hospital offers services and equipment that physicians like. But recruiting demands a large commitment of energy and resources by senior management, for contacting potential recruits, for maintaining enthusiasm among the community, physicians, and board members, and for purchasing necessary equipment.

Finding physicians who will practice in your area and whose spouses will also want to live in the area is time-consuming. Making a good impression during the physician's first visit and spending time with the spouse and family to be sure that questions are answered may be critical for successful recruiting. An unhappy spouse is a common reason for losing a physician. Even when you have a good recruiting company working on your behalf, you must still expect to spend a lot of time, over a long period, to recruit a new physician. The administrator must take the lead in recruiting if the hospital is to survive. You should know when physicians plan to retire or leave the area and plan for a period of overlap--it will be better for the hospital and community to have one more physician instead of one less. (Remember, losing a physician can result in others leaving too, as the remaining physicians feel the stress of the increased workload.) Even if you have a local physician who refuses to cooperate in recruiting, you must still recruit. One grantee's solution to this problem involved setting up a new hospital-based clinic for recruits.

Unless hospital administration or medical staff leaders are in contact with physicians looking for a rural practice, a recruiting firm is probably necessary. However, the process of selecting a recruiting firm must be handled carefully. The hospital administrator should get the names of potential firms from hospitals that have recruited successfully. Ideally, several firms should be considered. You should select firms that understand they are competing for your business. Ask for and check references. (Be sure to ask the references if they would use the firm again.) Insist on a written contract that clearly identifies a selected firm's obligations to the hospital. In addition, review the contract carefully before signing and making any advance payments. Be sure to discuss with the recruiting firm whether you will be liable for the full fee in the event that a recruited physician does not stay for a predetermined period (usually one to two years). Remember, strong community involvement in the entire process--retention as well as recruitment--is important.

Recruiting can be done. Grantees noted several successful recruitment strategies, including use of recruitment firms, offers of student loans, community support (for example, donating a physician salary guarantee), and networking with other physicians. Recruiting physicians who are known to existing physicians may be a successful strategy (one grantee recruited two family practitioners who graduated together and, two years later with the active participation of the first two recruits, recruited two more physicians from the same school). In addition, new projects implemented with the grants sometimes made a hospital more attractive to recruits. Altogether, 78 grantees were able to recruit 143 physicians with grant support. Two-thirds of these physicians were general or family practitioners. One-third were recruited from other rural areas. Table 7 presents selected statistics on physician recruitment.

TABLE 7

PHYSICIANS RECRUITED WITH THE GRANTS

	Total Recruited		Physicians Who Left Area by Grant's End	
	Number	Percentage of Total	Number	Percentage of Total
General or Family Practitioner	94	66	12	13
Internal Medicine	20	14	2	10
General Surgery	9	6	1	11
Orthopedic Surgery	3	2	0	--
Obstetrics and Gynecology	3	2	0	--
Pediatrics	2	1	0	--
Other	12	8	2	17
Total	**143**	**100**	**17**	**12**

MANAGEMENT PROJECTS

About one-quarter of the 1989 grantees and one-third of the 1990 grantees proposed management projects. Most intended to identify needed services through strategic planning or needs assessment. Some planned business improvements, such as purchasing new accounting systems. Others proposed marketing, space planning, and feasibility studies for specific services.

One case study grantee hired a rural hospital consultant who urged immediate changes in business practices, management structure, and quality assurance procedures to put the hospital on a sounder footing. The grantee implemented these aspects of the plan, and its financial position had improved by the end of the grant period.

Fifteen case study grantees used their grants to assess community needs. The majority identified primary and specialty care as priority needs and subsequently implemented projects to address these needs. In four grantee areas, the community wanted services such as child care, adult day care, wellness programs, and routine transportation. Two grantees implemented child care and adult day care without assessing their economic feasibility, and the services have not been used as much as grantees expected. The other grantees did feasibility assessments and put the wellness and routine transportation programs on hold after the assessments showed that they could not afford to subsidize them.

Projects such as computerization of accounting and, for a consortium of hospitals, consolidation of financial operations under one chief financial officer improved efficiency. For example, hospitals reduced days in net accounts receivable by substantial amounts, thus improving financial performance. Two case study grantees initiated grant-supported capital-fund drives to finance renovations and new construction. Others, believing that lack of information was inhibiting community use of hospital services, used their grants for marketing (for example, publishing quarterly newsletters, producing television spots, and writing newspaper articles).

STAFF TRAINING AND QUALITY OF CARE PROJECTS

Many grant projects involved staff training, which was primarily of two types: (1) training for specific services to be introduced by the grant project; and (2) general staff training. Several grantees trained staff for specific grant-funded services, such as emergency medical services, chemotherapy, and cardiac rehabilitation. Only 13 percent of grantees proposed more general staff training using mechanisms such as telecommunications networks to improve the overall quality of care by maintaining and improving the skills of physicians, nurses, and ancillary health professionals.

Two case study grantees maintained existing telecommunication links with university medical centers, using the grants to defray

the costs. These programs provided continuing medical education for physicians, as well as training for nurses and ancillary staff and, in one case, for the staff of other providers. One of these systems was also used for telemedicine consultations with university specialists. A third grantee dropped its proposed telecommunications program because the equipment costs exceeded the grant program's limit on capital expenditures.

Two case study grantees implemented quality improvement programs. One introduced continuous quality improvement to support its program of improved hospital management.[1] This hospital hired a consultant in utilization review and continuous quality improvement to visit the hospital monthly and provide staff training when necessary. The other added a consortium peer review program, which provided chart review, feedback, and physician training when necessary. Both grantees believed that these programs improved overall quality of care.

HOSPITAL CONSORTIA

Cooperating instead of competing with other providers has been proposed as a way of enhancing rural service delivery. Hospitals in a consortium or network can share resources and achieve economies of scale. The grant program facilitated cooperation by funding grantees in consortia to work on shared goals. Twenty-six consortia, including 93 hospitals, received grant awards. Some of the consortia were in existence before the grant program and proposed to use the grants to expand their areas of collaboration. Other consortia were set up in response to the grant program. Members of these consortia had no

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[1]Continuous Quality Improvement is a key component of a Total Quality Management program. It is a strategy for empowering employees at all levels of an organization to provide cost-effective, customer-oriented services. Establishing a program requires special training for team leaders and other employees. Many health organizations have successfully adopted Continuous Quality Improvement programs over the past few years.

experience working together (except if they were fellow members of a hospital system). Consortia hoped to use the grants to consolidate services, share resources, share the costs of planning, improve financial support systems, improve quality of care, recruit together, and train staff jointly.

Problems. One-fourth (six) of the consortia did not undertake any joint activities. Although some met periodically, they were unable to collaborate. Three of four consortia proposing to consolidate services and three of seven consortia proposing joint education and training programs were unable to implement their projects.

Among the four case study consortia, the most common reason for the lack of collaboration was physician losses at one member hospital. These losses impaired hospital finances and caused physician recruitment, rather than consortium activities, to take first priority.

Successes. One-fourth of the consortia collaborated in planning their projects but then implemented them without further collaboration. This planning-only type of collaboration has advantages, such as shared costs for feasibility assessments. These consortia undertook projects such as strategic planning and development of common goals (for example, staff education through telecommunications networks and individual service projects). They often used an external consultant or a coordinator from their multihospital system to assist in planning.

Just over half of the consortia appear to have collaborated fully in planning and implementing their projects, which included a regional service upgrade, joint recruiting, and consolidation of finances.

Some of the most successful collaborations took place among pre-existing rural hospital networks that had applied for grants to expand their areas of collaboration. Successful collaborations also occurred among consortia that were set up specifically to take advantage of the grants program. The smallest consortia (those with three or fewer members) were least likely to attempt any joint activities, although half collaborated fully. Even among

consortia that collaborated only in the planning stage or did not collaborate in any joint activities, members indicated that regular meetings helped administrators and clinical staff share information.

CHAPTER 6

CASE STUDIES OF SUCCESSFUL AND UNSUCCESSFUL GRANT PROJECTS

To illustrate in more detail hospital successes and failures in the grant program, this chapter provides case studies of three successful projects and then briefly summarizes seven unsuccessful ones. Our criteria for success are that the hospital (1) implemented its project goals and (2) met the grant program goals of improved access to care, improved quality of care, or improved hospital finances. The unsuccessful projects either were never implemented or were implemented but did not achieve grant program goals.

SUCCESSES

Case Study 1

A grantee implemented case management, upgraded the outpatient unit, and supported telecommunications, with beneficial effects on hospital finances, patient access, and quality of care. This small hospital is located in a remote, sparsely populated, low-income area of the Southwest. The hospital is the sole provider for two counties and also serves part of a third county. Its service area includes about 14,000 square miles and has a population of 18,000. About 6,000 of these people live in the town in which the hospital is located.

The grant project had three goals, which were all implemented: (1) recruit and fund a case manager; (2) upgrade the outpatient unit; and (3) support the existing telecommunications linkage to a health sciences center that provides continuing education and training. The goals were chosen to address specific problems. First, to reduce the size of its bad debt by improving collections, the hospital hired a case manager to screen cash-paying patients for their eligibility for medical assistance. Second, the outpatient area needed additional equipment and a face-lift to make it attractive to patients and visiting specialists. Finally, the hospital supported the telecommunications program because the hospital's remoteness from urban centers made it difficult for staff to obtain continuing education.

The hospital hired a bilingual case manager and, during the last year of the project, recruited a bilingual aide to assist her. These staff members screen uninsured inpatients and outpatients

(to see if they qualify for medical assistance or Medicare), plan discharges, and perform utilization review. As part of discharge planning, they check eligibility for programs such as food stamps, community care for aged and disabled people, a state prescription drug coverage program, and preventive care services. They also do followup (including home visits) to check that patients are adhering to their treatment plans. Furthermore, they provide community education, outreach at the hospital's Rural Health Clinics, counseling, and arrange for transportation when required. To improve their skills and knowledge, the hospital sends these staff members to seminars and workshops. The hospital credits the program with providing an important community service and with improving hospital revenues because of the increase in Medicaid, Medicare, and other local assistance program eligibility established by the case management staff.

Grant funds were used to decorate the outpatient room, to purchase laparoscopic equipment, and to send a nurse to other day surgery units and workshops to help her develop the new unit's policies and procedures. As a result of the facility upgrade, more specialists are visiting the hospital, and the number of outpatient surgeries has increased from 40 a month to between 60 and 70. The hospital believes that the improved outpatient area has helped in physician recruitment.

Grant funds were used to pay the monthly charge for the telecommunications link. These programs have enabled the hospital to train its emergency room staff on site, so that the trauma unit will be eligible for an upgrade to Level IV designation. The educational programs also allow physicians and other health professionals to get the continuing education needed to maintain their licenses. Furthermore, the physicians use the telecommunications link to consult with specialists.

This grantee's success derives from its clear articulation of the three problems to be addressed and the development of modest, achievable goals. Furthermore, the case management project was started with only one carefully picked staff member and expanded only after it was shown to be effective.

Case Study 2

A grantee implemented cardiac rehabilitation and pulmonary rehabilitation clinics, thus providing a community service, but hospital finances did not improve directly as a result. This large, growing hospital in the Southwest applied for a grant to implement outpatient cardiac and pulmonary rehabilitation. The hospital selected this project because heart attack and bypass surgery patients (mostly Medicare eligible) were being discharged from hospitals in the nearest urban area (50 miles away) without any rehabilitation followup. The hospital successfully implemented both services, but the pulmonary rehabilitation program was rarely used. The project was coordinated by a mid-level manager (the deputy director of nursing), but she delegated much of the organization and operations to the hospital's telemetry manager. As with any new project, the team had to overcome some difficulties to implement the services.

The problem areas were lack of continuity in staffing, physician reluctance to refer patients, and reimbursement difficulties. The program was initially implemented with part-time nurses, who often worked in the cardiac rehabilitation program during overtime hours. But use of many different part-time nurses resulted in no coordination with patients and with doctors. As a result, the project coordinator restaffed the program with an excellent intensive care unit nurse who worked closely with physicians and other dedicated staff. Initially, some primary care physicians feared that they would lose their cardiac patients to the program's cardiologist medical director, but after two years of education about the program, they now refer patients to it.

The program experienced frequent denial of claims by Medicare in the early days. Program staff resolved this problem by attending an out-of-town seminar on how to obtain payment for cardiac rehabilitation (doing a better job of getting patients precertified) and subsequently assigning all billings to one person--who learned what was required to get reimbursement.

The cardiac program was actively expanding after three years of operations, with plans to start a support group for spouses. The project coordinator credited the smooth implementation of the project to a detailed management plan. This plan (prepared for

the grant application) described activities that would need to be completed, included a schedule for completing them, and identified staff responsibilities.

The hospital perceives several benefits of the grant project. First, it has enabled the hospital to provide a community service--patients do not have to travel an hour to the nearest urban program, so their likelihood of receiving service has increased. The project also improved the skills of the middle managers who implemented and ran the program. Finally, although the project breaks even rather than making money, it has been beneficial indirectly as a public relations tool. It is highly visible in the community, and participants even wear program T-shirts. This grantee encountered a number of problems during the grant project but overcame them. The grantee was successful because it defined its goals narrowly (to develop a community service that would break even by the end of the grant project); gave responsibility for planning and implementing the project to a capable, middle-level manager who was accountable to the administrator; and deployed staff who could interact well with patients and physicians.

Case Study 3

A grantee improved its status in the community by establishing specialty clinics under the coordination of a nurse manager. This small hospital, affiliated with a multihospital system, is located in an area of the Midwest with relatively high population density but low income. It serves 20,000 people and is located only 20 miles from the nearest town, which has a Rural Referral Center. The grant project to expand the hospital's specialty clinics was successful. The hospital also opened two Rural Health Clinics with grant funds. Aside from providing a useful service to the community, the specialty clinics improved the hospital's image.

The hospital recruited a registered nurse to coordinate the clinics and renovated an area of the facility to house them. The project coordinator started the program by asking local doctors what specialty clinics they thought were needed and by doing a marketing study to find out what the community wanted. She then recruited physicians from practices in the nearest town where the Rural Referral Center is located. The Rural Health

Clinics were not part of the original proposal, but the hospital decided to add them.

The nurse coordinator was an important contributor to the success of the specialty clinics. She coordinated clinic hours of operation, patient appointment times, and patient records with the physicians and worked with hospital administration to ensure staff support for the clinics. The hospital had run specialty clinics before, but they were not well coordinated.[1]

Maintaining specialty clinics requires constant effort. The project coordinator had to work on publicity, to make sure that the community knew services were available. Initially, the hospital was not advertising the clinics, and they were not used as much as they could have been. Later, the hospital publicized the clinics through a newsletter, advertisements in the local newspaper, and speaking engagements at local organizations.

The coordinator also had to work constantly on physician issues. For example, it was unclear who owned patient records. The grantee resolved this problem by allowing physicians a choice: keep their own patient records or have them maintained by the Rural Health Clinics. Second, there was turnover among specialists visiting the hospital, and the coordinator had to work with physicians to maintain or replace certain clinics. During the grant period, the hospital had as many as 14 specialty clinics; for various reasons, this number dropped to 12 by the end of the period. New physicians who had not yet built up a full caseload were the most receptive to providing clinics. As soon as their practices became busy, however, the doctors' interest in providing clinics at the rural hospital sometimes declined. The hospital usually was able to replace these physicians with doctors from other practices.

Lack of equipment also resulted in loss of two specialist clinics. The oncologist wanted to be able to provide chemotherapy, but

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[1]Staff from successful specialty clinic programs at other hospitals also mentioned the importance of nurse coordinators to clinic success.

the hospital was unable to offer this service because it lacked the ventilator hood required for mixing the chemicals. Physicians providing a gastroenterology clinic stopped doing so after the hospital that provided the endoscopy equipment noticed that its own rate of endoscopies was falling and stopped letting physicians take the equipment to the grantee hospital.

The hospital's success was due to careful selection and planning of specialty clinics and the nurse coordinator's unremitting efforts to maintain the clinics. As a result of these efforts, the hospital more than doubled the number of specialty clinic visits between the year it won the grant and the final grant year (from 2,294 to 5,235).

FAILURES

The grants described in this section were unsuccessful. In some cases, the projects were ill chosen or ill planned; in others, the hospital simply could not implement a reasonable project. The summaries here describe the projects and give the principal reasons for the lack of success.

Case Study 4

A mobile clinic was implemented, but it was unreliable and not heavily used. This hospital chose to introduce a mobile health clinic to improve access to primary care for outlying patients who had difficulty traveling to the hospital. The mobile unit was purchased by staff who did not know much about mobile clinics and who did not spend much time researching the features that they would need. After the unit arrived, the hospital had serious problems with it. Local bridges were too narrow for the unit to cross, so it had to travel by indirect routes to its destinations. Electrical power available at destinations was insufficient to run the X-ray unit, so a generator had to be ordered to supply the necessary power. The unit also lacked a wheelchair lift and required frequent repairs because poor road surfaces resulted in considerable wear and tear.

Because of these problems, the clinic was not a reliable source of care. Patients stopped believing it would arrive when

scheduled and hence stopped using it. The hospital planned to continue the service for six months after the grant period. If the unit was not making money at that time, the hospital planned to terminate the service. In retrospect, the hospital felt that it would have been wiser to open primary care clinics in selected locations instead of purchasing the mobile clinic.[2] This grantee could have averted these problems if it had reviewed the types of features the clinic would need, assessed local roads, and considered the advantages of providing in-situ clinics before implementing the mobile health clinic.

Case Study 5

A grantee planned to upgrade its emergency transportation service to advanced life support (paramedic), but the service was not implemented. This hospital planned to upgrade its emergency medical transportation by training existing staff to perform at a higher level. Staff volunteered to be trained as paramedics (capable of providing advanced life support and trauma management). Unfortunately, not all staff attended training at the same time, and not all those who did attend passed the examination. As a result, the hospital was never able to get enough trained staff to implement the higher level of care. Even worse, those who had passed the examination quit to join other units in which they could maintain their paramedic qualifications. (It is not unusual for hospitals to lose trained paramedics to larger services.) The hospital then sold the ambulance service to a private contractor. This grantee could have had a successful program if it had used more realistic assumptions about how many staff could be trained and about rates of paramedic certification. This process would have helped the hospital to realize (as it did in hindsight) that it should hire enough trained paramedics to start the unit and then expand by training existing staff.

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[2]Another hospital with a mobile health clinic project had comparable problems. It eventually replaced its mobile health clinic with primary health care clinics in some of the towns the mobile unit had visited.

Case Study 6 *A consortium planned a nursing pool, but it was not implemented.* This multihospital consortium hoped to pool its nursing staff in order to overcome some of the peak load problems that small hospitals encounter. Unfortunately, this goal could not be met because the nursing staff at one hospital objected violently. The nurses felt loyalty to their own hospital and refused to consider a pool. Program administrators believe that they could have implemented the nursing pool successfully if they had done a better job of preparing staff for the change and listening to their concerns.

Case Study 7 *A grantee recruited and trained a nurse midwife, but she was not added to the hospital staff.* This grantee hospital planned to recruit a nurse midwife to provide prenatal and obstetric services. After a long search, no qualified applicant could be found, so the hospital decided to pay tuition for a registered nurse to train as a nurse midwife and contract with that nurse to serve the hospital after her training. Two years after the grant began, a new administrator was appointed, and he reviewed the grant project. After discussions with the nursing department at the hospital, a local community health center, and two visiting obstetricians who provided prenatal services but did not deliver babies locally, the administrator determined that there was no longer support for nurse-midwifery at the hospital. The project was abandoned, but the hospital continued its financial support for the nurse's education. The problem seems to have resulted from an inadequate assessment of feasibility and support by the grant applicant. The new administrator conducted such an assessment and refocused the grant project on its second goal--introducing specialty clinics--in which it was successful.

Case Study 8 *No goals met.* This very small, remote hospital originally applied for a grant to plan a home health agency and an assisted living facility. During its first grant year, the hospital undertook planning activities. It used the grant to have architectural plans drawn up for an assisted living facility and started looking for sources of mortgages. It also drew up plans for opening a satellite home health agency to a distant agency and applied for fiscal intermediary approval of the plan; however, the plan was

disapproved. The grantee applied for further grant funding to continue planning. Eventually, the grantee dropped its assisted living goal because it could not find any funding source for construction. The grantee had meanwhile decided to develop its own home health agency. At the end of the grant period, it still had not yet been certified as a home health agency, although a certification visit was imminent. At the time of grant award, the administrator was fairly new at the hospital, and most of his attention was focused on turning the hospital's organization and finances around (it was about to lose certification when he arrived). The hospital might have done better if the administrator had focused on one goal--home health--instead of two and if more staff time had been devoted to the project. The administrator spent little time on the project and reported that there was nobody on staff to whom he could delegate the project. He could instead have recruited an experienced nurse to plan and implement the agency, which could then have been started much sooner and benefited both hospital and community.

Case Study 9

A grantee was unable to open a ventilator unit. This grantee planned to be the first facility in its state to open a long-term care unit for ventilator dependent patients that it hoped would draw patients from all over the state. It expected that this service would prove profitable as well as provide a needed service. At the time of award, the state's Medicaid program did not pay enhanced rates for this service, but the grantee expected that it would be able to persuade the state to pay for it. On the basis of this assumption, the grantee purchased the necessary equipment and trained the staff to serve ventilator dependent patients. It also lobbied for an adequate reimbursement rate to cover the costs of the service. However, this hospital's assessment that Medicaid would make enhanced payments for the service was faulty, and 3 years after grant award, it still had not implemented the service. The ventilator equipment purchased with the grant was in storage. A more realistic environmental assessment would have suggested that the grantee undertake a less political project.

Case Study 10

A grantee was unable to implement any of multiple goals. This small, southern hospital had multiple goals, including conducting needs assessment, implementing swing beds, upgrading its outpatient unit, and converting to a rural primary care hospital. During the 3-year grant program, it initiated a needs assessment and purchased some equipment for its emergency room. But no focused activities took place, and the grantee spent little of its grant funds. The problem in this hospital was lack of leadership. Between the time when the hospital applied for the grant and the end of the grant project, the hospital had five different administrators and a similar number of financial officers. As a result, nobody was responsible for the grant project and the grantee was never able to follow up on any of the initial activities. In the last year of the grant, the hospital board, which was highly political, was restructured, and an administrator was found who stayed and provided leadership--a prerequisite for grant project implementation.

CHAPTER 7

GRANT IMPACTS ON THE HOSPITAL AND COMMUNITY

In keeping with the intent of the transition grant program, grantees proposed and implemented projects aimed at improving their finances or management. These projects were also expected to benefit rural communities by introducing needed but previously unavailable services, improving other aspects of access to care (for example, transportation availability), or improving the quality of care. Perhaps the grants' most important benefit was to enhance the viability of hospitals and, consequently, to help ensure the long-term availability of health services in these rural communities.

Getting a grant award and using it to implement a new service are unlikely to avert closure if your hospital is in trouble. But many grantees reported positive impacts of the grant projects--on finances, on community access to services, and on staff morale. Nevertheless, we caution that financial impacts were not easily measurable. In general, our analysis of revenues and short-term measures of financial performance during the grant period did not show improvements relative to the 2 years before the grant or relative to all small rural hospitals.

A variety of new services were added with grant support. Not only were physicians and other health professionals recruited, but grantees also believed that the new services enhanced their ability to meet community needs, and a few believed that the new service helped them avert closure. Some grantees also reported that the projects boosted staff morale, helped improve community perceptions of the hospital, and increased utilization.

HOSPITAL IMPACTS

About one-fifth of the 1990 grantees believed that the grant projects had improved their finances. Most case study grantees felt that the grant projects would contribute to their hospitals' long-term viability.

Effects on Finances

Some grantees hoped to *increase revenues* by adding new services; others hoped to *reduce costs* by improving management or steering patients to lower-cost services. Case study grantees provided anecdotal evidence for accomplishing these goals and realizing other financial benefits.

Grantees reported that their revenues had increased *directly* as a result of physician recruitment. These doctors admitted more patients to the hospital and introduced needed but previously unavailable services (for example, outpatient surgery). The grants also helped increase revenues by improving collection for rendered services (for example, by introducing case management or computerizing billing), and by supporting new services that increased the hospital's proportion of private-paying patients (for example, outpatient mental health clinics) or that resulted in increased use of ancillary services (for example, Rural Health Clinics).

According to grantees, other projects (for example, community and patient education programs) increased hospital revenues *indirectly* by improving the hospital's reputation or the community's awareness of services offered. Some projects improved the community's perception of the quality of services already available and attracted more patients (for example, through renovation and new construction, purchase of new equipment, and staff training). These changes all helped enhance the hospital's reputation within the community which, in turn, resulted in higher utilization and fewer area residents going elsewhere for care. Other hospitals reported secondary benefits, including an increase in volunteering and financial support from the community.

Grantees reduced their costs using diverse strategies. Some indicated that the introduction of routine medical transportation services helped reduce the number of nonemergency calls for ambulances; others noted that the implementation of Rural Health Clinics or primary care clinics at the hospital helped steer primary care patients away from emergency rooms. Staff training was also used as a cost-cutting strategy. By training nurses to provide coverage for multiple programs (such as the emergency room and the cardiac rehabilitation or inpatient

psychiatric and chemical dependency clinics), some grantees achieved more efficient staffing. Using scholarships as an incentive for its nursing staff to upgrade their skills, one grantee was able to stop using expensive temporary-agency nurses.

Grantees perceived an improvement in the *long-term financial viability* of hospitals as a result of the grant projects. According to grantees, the grants helped them recruit physicians and other health professionals, buy new equipment, upgrade staff skills, and add needed services. In a cycle of interrelated events, successful projects (such as outpatient specialty clinics, home health, and routine medical transportation) enhanced hospitals' reputations within their communities which, in turn, encouraged utilization of new and existing services. Greater utilization further strengthened hospitals' financial position, perhaps making the hospitals more attractive practice locations for potential recruits.

About five percent of the 1990 grantees had seriously considered closing in the year before grant award, five (two percent) closed during the grant period, and only one percent were seriously considering closure by grants end. Five case study hospitals believed that the grants had been instrumental in helping them avert closure, reporting that the grants had helped them increase revenues by recruiting physicians or adding needed services (such as home health and Rural Health Clinics) during cash-flow crises.

Other Effects

There was almost universal consensus among grantees that one of the unexpected benefits of the grant projects was improved staff morale. Staff perceived the hospital to be better than other applicants because it had won a grant. Introducing proposed services demonstrated to staff members their own capacity to innovate, and overcoming implementation problems gave them a sense of empowerment.

The grant projects gave grantees an opportunity to develop the skills of mid-level hospital managers by appointing these staff to the project coordinator role--which many hospitals found valuable. Coordinators noted that managing the grant projects

encouraged more disciplined thinking and the development of new ideas. It also helped them learn to develop plans, set goals, and cultivate better relationships with other hospital staff.

Twenty percent of hospitals receiving grants subsequently were awarded comparable-size grants from other sources, indicating that the grant award may have given them the confidence to learn to tap other funding sources.

COMMUNITY IMPACTS

Our evaluation provided no evidence of measurable improvements in service availability or the quality of the services available in the grantees' communities during the grant period. Grantees believed, however, that by introducing new services, purchasing equipment, and recruiting physicians, among other accomplishments, their projects benefited communities in important ways.[1]

Grantees implemented many services and programs with grant funds. Projects benefited communities by (1) increasing the number of services available locally, and (2) reducing the time local residents had to spend traveling to receive services (for example, for outpatient specialty clinics or cardiac rehabilitation).

Most case study grantees also believed that their ability to meet community needs had been enhanced by the projects. Often, they attributed this improvement to expanded availability of specialty outpatient clinics, to new equipment purchases, and to physician recruitment. By introducing routine medical

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[1]For example, among 1990 grantees, 83 percent reported that community support of all kinds (utilization of hospital services, financial support through taxes or philanthropic giving, and volunteering) had increased as a result of the grant project. Only two-thirds of the case study grantees, however, said that the community was aware of the grant project, and only one-quarter reported aggressive publicity for the project.

transportation and implementing Rural Health Clinics or primary care clinics in towns without doctors, some grantees believed that access to care in their service area had improved significantly.

One-third of the 1990 grantees reported that their projects had improved the quality of care they provided--a perception consistent with their report of increased use of hospital services by local residents and their belief that hospital status in the community had improved as a result of their grant projects. Staff training and quality assurance projects, new equipment purchases, and successful recruitment were all seen as factors contributing to this improvement.

APPENDIX A

LESSONS FROM CASE STUDY GRANTEES

This appendix provides more detailed information about the services implemented by grantees. The service-by-service summaries use statistical information from 326 grantees awarded grants in 1989 and 1990 and implementation information from 98 case study grantees drawn from the larger group.

Statistics are provided on:

- The number of grantees proposing to implement the service
- The number of grantees implementing the service. Because many grantees went through a planning process before selecting the services they would implement, the number implementing the service can be larger than the number proposing to implement it.
- The implementation rate (the number of 1990 grantees implementing a program or service that originally proposed it as a grant goal, divided by the number of grantees that proposed implementing it)
- Average implementing time (the number of months from grant award until the service was available)
- Number of patients seen per month (this is the mean for 1989 grantees and the median or midpoint for 1990 grantees)
- Percent of grantees for whom the service was financially self-supporting by the end of the grant period

The summaries illustrate issues arising during implementation and factors that affected project success or made implementation more difficult. The implementation discussion is summarized under the following headings:

- Problems During Implementation
- Problems After Implementation
- Achieving Success

- Maintaining Service
- Points to Consider

For some services, few or no case studies exist to illustrate experience with a particular type of service. For these services, we provide only the statistical information.

The summaries are organized as follows. First, we describe outpatient and emergency services, second, inpatient services, then, third, preventive, community and social services, transportation and diagnostic services. Services are listed in the order they appear in tables 1, 2, and 3.

OUTPATIENT SURGERY

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	7
Grantees Implementing	20 (15.2%)	35 (18.0%)
Implementation Rate	NA	57%
Average Implementing Time (Months)	24	18
Number of Patients per Month	6	22*
Financially Self-Supporting at Grant End	80%	94%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One grantee was unable to implement the service during the grant period because planning took more than three years. Others reported difficulties either persuading local surgeons or recruiting visiting surgeons to provide outpatient surgery. Some grantees had to drop their projects altogether because the hospital was not licensed as a general hospital, and was thus unable to offer surgical services.

Problems After Implementation

One grantee attributed low utilization of the service to the community's lack of familiarity with the new option of outpatient surgery at the hospital.

Achieving Success

Feasibility studies to assess the viability of adding the service contributed to the success of some programs. Grantees also found that having a project coordinator to coordinate with the director of nursing, visiting specialists, and other hospital staff, to schedule surgical suites, and to manage the program was helpful. The coordinator visited similar programs elsewhere prior to implementing the program.

Maintaining Service

Having a nurse coordinator to manage the clinics, a case manager to refer patients to the service through community clinics, and promoting the service with lots of publicity once it had been established all helped to increase use.

Points to Consider

- Outpatient surgery requires anesthetist services; without sufficient volume, certified registered nurse anesthetists may resign because their skills decline.

- Hospitals used grant funds to renovate outpatient surgery areas, purchase laparoscopic equipment, pay program coordinators, and provide salary guarantees for recruited surgeons. Grantees often mentioned that the hospital had to cover a large part of the implementation costs but also that they could not have implemented the services without the grant's help.

- Few grantees attributed significant financial gains to the implementation of outpatient surgery. One case study attributed a substantial improvement in the community's access to care, as patients no longer had to travel long distances (more than 150 miles round-trip) to get outpatient surgery. Others mentioned that the new outpatient services generated some revenues, and increased hospital recognition within the community. One case study grantee said the project assisted the hospital financially by increasing the number of private-pay patients.

EMERGENCY ROOM

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	9
Grantees Implementing	26 (19.7%)	29 (14.9%)
Implementation Rate	NA	67%
Average Implementing Time (Months)	25	16
Number of Patients per Month	421	438*
Financially Self-Supporting at Grant End	73%	67%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One case study grantee recruited a physician assistant instead of a nurse practitioner (as originally proposed) because of difficulties recruiting nurse practitioners.

Maintaining Service

Physicians in residency programs in the nearest cities can provide weekend coverage to help maintain service. One case study grantee commented that using residents to provide weekend coverage for the emergency room had helped with physician recruitment. This arrangement made the hospital more attractive, as local physicians were on call less often.

Points to Consider

- One case study grantee believed reopening its emergency room service would have a positive financial impact on the hospital but that it would only be noticeable in the long term.

- One case study grantee used grant funds to remodel its emergency room so that trauma patients were brought in directly to an examining area and to create a separate waiting area for people accompanying patients. This grantee attributed to the project significant improvements in staff efficiency and the quality of care provided, as well as financial gains.

RURAL HEALTH CLINICS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	10
Grantees Implementing	8 (6.1%)	40 (20.6%)
Implementation Rate	NA	90%
Average Implementing Time (Months)	23	17
Number of Patients per Month	461	322*
Financially Self-Supporting at Grant End	88%	53%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

Agreement between one grantee and a local medical school to rotate residents through the Rural Health Clinics fell through because of the hospital's inability to recruit a board-certified family practitioner. Although the grantee implemented its clinic with a local general practitioner, this made staffing more difficult. In addition, some grantees had difficulty recruiting physicians to be medical directors and physician assistants and nurse practitioners to staff their clinics.

Problems After Implementation

Some grantees found caseload slow to build: one grantee had to close one of the four clinics it had implemented because of low utilization. Some grantees had reimbursement delays because of paperwork difficulties. Grantees often considered regulations to be complicated.

Achieving Success

Grantees suggested having a project coordinator to set up the clinics and help staff work together effectively, and a consultant to help get Medicare certification quickly and comply with regulations. Finding a physician willing to act as the clinic's medical director and supervise mid-level staff was a factor in the success of some clinics. Grantees implemented Rural Health Clinics by (1) building new clinics, (2) converting retiring physicians' practices, or (3) taking over clinics from hospitals that had closed. Grantees discovered that it is helpful to complete feasibility studies to assess the viability of converting a practice before purchasing it from a retiring physician. One grantee also recommended establishing the physician's willingness to sell.

Maintaining Service

The community involvement of staff (both physician and nurse practitioner or physician assistant) may be necessary to build demand for the service. If caseload is slow to build, planning financial support of the service for a year or more after grant funding ceases will help to maintain service.

Points to Consider

- "Rural Health Clinic" is a federal designation under Public Law 95-210 that allows full-cost reimbursement but requires the use of mid-level health professionals. To obtain this designation, the clinic must also be located in a designated Health Professional Shortage Area.

- Among outpatient and emergency services, Rural Health Clinics were the least likely to be financially self-supporting by grant's end.

- Grantees often implemented Rural Health Clinics successfully in towns without doctors. Some grantees opened multiple Rural Health Clinics that operated part-time and were supervised by a single physician.

- Some grantees opened hospital-based Rural Health Clinics to steer primary care patients out of the emergency room and save the hospital money. Some grantees believed that opening Rural Health Clinics had enhanced the hospital's status within the community: some noted that the Rural Health Clinics generated referrals for hospital inpatient, outpatient specialty, and ancillary services.

- Grant funds were often used to recruit, buy clinics, pay staff salaries, or cover start-up costs. Many grantees mentioned that the grants did not cover all planning and implementation costs.

- Few case study grantees attributed significant financial effects to the implementation of Rural Health Clinics. Some grantees believed the projects had helped the hospital somewhat by expanding its service area--as individuals who would otherwise go to other facilities were now being referred to the hospital. Some hospitals said the grants had provided funds that (1) allowed the facility to pursue necessary transitions at times of financial distress (for example, by expanding services, conducting strategic planning, and providing staff with further training), (2) offset expenses, and (3) helped avert closure during cash-flow crises.

PHYSICAL THERAPY

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	5
Grantees Implementing	25 (18.9%)	23 (11.9%)
Implementation Rate	NA	60%
Average Implementing Time (Months)	21	16
Number of Patients per Month	711	417*
Financially Self-Supporting at Grant End	100%	100%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

Inability to hire a physical therapist forced one grantee to contract for the service--a very expensive option. Another grantee chose not to implement physical therapy rather than pay the high salary requested by candidates.

Points to Consider

- All successful programs implemented by 1989 and 1990 grantees were financially self-supporting by grant's end.

- One case study grantee found that contracting the service to an outside therapist, although expensive, still cost less than keeping patients in the hospital.

- One case study grantee mentioned that the hospital had to cover some project costs but also noted that it could not have added both home health and physical therapy services without the grant.

CARDIAC REHABILITATION AND CARDIAC CLINICS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	16
Grantees Implementing	16 (12.1%)	25 (12.9%)
Implementation Rate	NA	88%
Average Implementing Time (Months)	23	13
Number of Patients per Month	71	63*
Financially Self-Supporting at Grant End	81%	71%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One grantee was unable to persuade local physicians to provide cardiac rehabilitation services at the hospital because the doctors preferred to offer the service at their offices. Because of the equipment and space requirements, the physicians eventually approached the hospital to take over the program, but implementation was delayed significantly. Another grantee found its implementation schedule to be overly optimistic. One small hospital had difficulties because it had no staff dedicated to setting up the clinic and writing procedures.

Problems After Implementation

Some grantees had difficulties building up caseload because local physicians were hesitant to refer patients to the new service. Grantees that implemented the service in combination with a physical therapy or wellness program, however, sometimes

found that they had too little space because of greater-than-planned utilization or equipment space requirements.

Achieving Success

Planning was an important factor in the success of these projects. Needs-assessment and feasibility studies helped to ensure sufficient patient volume, while space planning ensured proper program layout. Some participants attended workshops and seminars on cardiac clinics and rehabilitation before implementing the projects, and some grantees found it helpful to talk to clinicians from other hospitals with the service. Having a project coordinator to work with local physicians and visiting cardiologists was also considered helpful.

Maintaining Service

Financial support planning for the short-to-medium run following implementation is vital to continued service. Physicians must be willing to refer patients to the new service, as well. Having a highly skilled cardiac nurse run the program also helps maintain high-quality service.

Points to Consider

- Some grantees implemented these programs in combination with services like pulmonary rehabilitation, physical rehabilitation, and wellness programs, and some provided family education and support groups.

- One small hospital staffed the program with an emergency room nurse. Several staff were trained to provide backup. Neither the emergency room nurse nor the back-up nurses were dedicated to the program, so the marginal cost of running the program was small.

- Two grantees wished they could provide transportation services as patients are generally too sick to arrange transportation for themselves shortly after a heart attack or heart surgery.

- Hospitals often mentioned that the grants had not covered all planning and implementation costs. Some grantees used their grant funds for needs assessment, feasibility studies, program planning, and recruitment. One grantee commented that the grant had provided additional resources that were necessary for proper planning and implementation of its program.

- Few grantees attributed significant financial gains to implementation of cardiac rehabilitation programs or cardiac clinics. One grantee mentioned that the project may have increased revenues marginally but that primarily it had provided an opportunity for staff development. Another grantee mentioned that the project had helped the hospital develop new revenue sources and become more diverse.

- Grantees attributed to the project a significant improvement in the community's access to care as patients no longer had to travel long distances (in one case, more than 100 miles) for the service.

PRIMARY CARE CLINICS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	11
Grantees Implementing	15 (11.4%)	23 (11.9%)
Implementation Rate	NA	36%
Average Implementing Time (Months)	26	18
Number of Patients per Month	559	330*
Financially Self-Supporting at Grant End	68%	68%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

Difficulties recruiting physicians delayed implementation (by as much as 2 years) for some grantees.

Problems After Implementation

One grantee reported difficulties building caseload.

Maintaining Service

Promotion of the service, and continuing publicity once the service had been implemented, were critical to maintaining the service.

Points to Consider

- This category includes all physician-staffed clinics that did not qualify as Rural Health Clinics.

- Some grantees implemented clinics by hiring doctors in residency training.

- Hospitals often mentioned that the grants had not covered all project costs. Some grantees used their grant funds for recruitment and clinic start-up costs. One grantee said the grant helped the hospital open its primary care clinic sooner.

- Few grantees attributed significant financial gains to primary care clinic implementation. One grantee mentioned that the project had increased hospital revenues through referrals for ancillary services, and that it had had an indirect effect by bringing to the hospital a doctor with a very good reputation who attracts patients. Another grantee opening multiple clinics said the project had helped the hospital secure new markets.

UNSPECIFIED OUTPATIENT SPECIALTY CLINICS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	23
Grantees Implementing	5 (3.8%)	13 (6.7%)
Implementation Rate	NA	61%
Average Implementing Time (Months)	15	NA
Number of Patients per Month	7	NA
Financially Self-Supporting at Grant End	60%	NA

NOTES: NA = not available.

Lessons from Case Study Grantees

Problems During Implementation

One grantee dropped the goal of adding specialty clinics because local physicians were not interested in having visiting specialists. Another could not recruit specialists to the area, and thus could not implement desired new services. One grantee's expansion of its dialysis unit was delayed because the hospital did not have the funds to pay for equipment purchases beyond the grant limit on capital expenditures.

Problems After Implementation

Grantees reported low utilization of the clinics implemented.

Achieving Success

A needs-assessment study prior to implementation of the project may help to ensure sufficient patient volume. A project coordinator was also cited as a key to successful implementation.

Points to Consider

- For 1989 grantees, this category includes only pulmonary rehabilitation clinics, while for 1990 grantees, it includes obstetrics/gynecology, podiatry, rheumatism, dialysis, and homeopathic medical clinics.

- Some grantees used their funds to pay for marketing studies, recruitment, or visiting specialists' salaries. One grantee mentioned that the hospital paid for most equipment purchases.

- No case study grantee attributed a significant financial gain to this project. One grantee said the grant had allowed the hospital to provide more varied services. Another grantee mentioned that the project had generated some indirect revenue for the hospital as specialists ordered ancillary services and increased the number of private-pay patients.

ONCOLOGY AND CHEMOTHERAPY SERVICES

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	1
Grantees Implementing	6 (4.5%)	11 (5.7%)
Implementation Rate	NA	100%
Average Implementing Time (Months)	19	17
Number of Patients per Month	75	14*
Financially Self-Supporting at Grant End	50%	63%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One case study grantee had difficulty attracting oncologists. It had to pay a per diem fee, reimburse oncologists' travel costs, and train hospital nurses to administer its program in order to persuade the oncologists to provide services at the hospital.

Problems After Implementation

One case study grantee reported that the high volume of patients required changing locations after the program had been implemented. Another grantee could not persuade the major oncology group to which local physicians referred their patients to refer patients to the outpatient chemotherapy program.

Achieving Success

Training home health nurses to provide outpatient chemotherapy provided flexibility in staffing for variations in patient load in the chemotherapy program.

Points to Consider

- One case study grantee said the grant provided seed money to start the hospital's oncology and chemotherapy program. The program, which also provides a low volume of inpatient services, is now producing revenue and has also enhanced the hospital's status in the community.

OCCUPATIONAL THERAPY

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	1
Grantees Implementing	4 (3.0%)	12 (6.2%)
Implementation Rate	NA	100%
Average Implementing Time (Months)	15	19
Number of Patients per Month	178	53*
Financially Self-Supporting at Grant End	100%	100%

NOTES: NA = not available.
* = median.

MENTAL HEALTH CLINICS AND OUTREACH PROGRAMS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	7
Grantees Implementing	5 (3.8%)	10 (5.2%)
Implementation Rate	NA	57%
Average Implementing Time (Months)	22	17
Number of Patients per Month	72	80*
Financially Self-Supporting at Grant End	60%	66%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems After Implementation

One case study grantee recruited a psychologist but reported problems with reimbursement because Medicaid paid a reduced fee for master's-level staff. Another grantee found that the service was not covering costs because of inefficient billing.

Achieving Success

Having a project coordinator throughout the planning and implementation stages of the project helped some grantees achieve success. A feasibility assessment to show the viability of in-hospital versus satellite programs was also found to be helpful.

Maintaining Service

Referrals from other providers, such as community and migrant health centers, were important for maintaining service. Grantees also found that proper billing of the services ensured continuing financial self-support.

Points to Consider

- Transportation services were important for the success of one grantee's day-treatment program for the elderly.
- One grantee arranged for a local social worker to do assessments under contract.
- After doing a feasibility study, one grantee implemented an outpatient program in the hospital instead of the satellite clinic it had originally proposed.
- No case study grantee attributed significant financial gains for the hospital to its project. One grantee had been having reimbursement problems with private insurance companies for inpatient services. The addition of outpatient services increased reimbursement so that the hospital's mental health program (inpatient and outpatient) breaks even. Another grantee said that the addition of outpatient mental health services had helped stabilize the hospital's business.

EAR, NOSE, AND THROAT CLINICS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	NA
Grantees Implementing	7 (5.3%)	8 (4.1%)
Implementation Rate	NA	NA
Average Implementing Time (Months)	18	16
Number of Patients per Month	15	20*
Financially Self-Supporting at Grant End	43%	100%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Achieving Success

One grantee had a visiting specialist who brought his residents with him. That specialist felt that the experience was advantageous to the residents, as it exposed them to a wider variety of conditions, such as pediatric problems, than they might otherwise have seen.

Points to Consider

- All eight programs implemented by 1990 grantees were financially self-supporting by grant's end, but the majority of programs implemented by 1989 grantees were not.

MOBILE HEALTH CLINICS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	3
Grantees Implementing	4 (3.0%)	8 (4.1%)
Implementation Rate	NA	100%
Average Implementing Time (Months)	13	11
Number of Patients per Month	510	72*
Financially Self-Supporting at Grant End	50%	60%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems After Implementation

One grantee found that frequent repairs to its mobile unit made it costly to maintain and unreliable (see Chapter 6). Another service was not well used once implemented, and one vehicle was not handicapped accessible.

Points to Consider

- After implementing, one grantee found the unit to be a moving liability. The vehicle was totaled in an accident and the grantee decided to drop the project in favor of establishing fixed-site primary care clinics.

- Because of low utilization, high maintenance costs, and the hospital's inability to subsidize the service, one grantee said it would discontinue its mobile clinic service unless it became self-supporting within 6 months after the end of the grant.

SWING BEDS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	4
Grantees Implementing	11 (8.3%)	12 (6.2%)
Implementation Rate	NA	75%
Average Implementing Time (Months)	30	23
Number of Patients per Month	7	8*
Financially Self-Supporting at Grant End	100%	91%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems After Implementation

One grantee had reimbursement problems because of complex regulations.

Points to Consider

- Five 1990 grantees implemented swing beds in combination with skilled nursing units.
- One grantee wished for a comprehensive and up-to-date reference on swing bed regulations and reimbursement requirements. The hospital staff did not have such a resource, and often experienced reimbursement delays because of regulations that varied based on each patient's condition or admitting diagnosis.

NURSING HOMES, SKILLED NURSING, AND TRANSITIONAL CARE UNITS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	13
Grantees Implementing	7 (5.3%)	14 (7.2%)
Implementation Rate	NA	82%
Average Implementing Time (Months)	27	23
Number of Patients per Month	28	36*
Financially Self-Supporting at Grant End	85%	100%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

Planning and regulation difficulties caused the most delays. One grantee found planning took longer than expected. One faced construction delays because of difficulties meeting fire wall regulations; another had higher-than-expected construction costs in order to meet the fire code. In addition, implementing one grantee's transitional care unit took over 2 years because of difficulties meeting regulations.

Some grantees had difficulties getting the Certificate of Need required to open these facilities in some states: one had implementation delayed for one year because of litigation with five local nursing homes trying to stop the hospital from getting the Certificate of Need for its skilled nursing unit. Another had to drop its goal of purchasing a local nursing home because the owners were not interested in selling.

Problems After Implementation

One grantee reported that physicians were not keeping records up-to-date, which slowed billing. One grantee implementing a transitional care unit had difficulties covering costs because the facility was being reimbursed by Medicare as a skilled nursing facility. The hospital appealed, but adjustment would not occur until the unit had been in operation for one year.

Achieving Success

Careful planning and preparation were significant factors for successful implementation of projects. Grantees found that careful feasibility studies to determine the size of the facility and staff eased implementation of the program. In addition, a project coordinator could develop procedures, hire and train staff (before the unit opened), and organize certification. One grantee found that implementation moved rapidly when a board member acted as the construction coordinator. Supplementary financing may be necessary to cover construction costs if extensive renovation or new construction is required to open distinct patient units.

Points to Consider

- All skilled nursing units implemented were financially self-supporting by grant's end.

- The case study grantee whose implementation was delayed by litigation noted that local nursing homes opposed the hospital's skilled nursing facility because they did not understand that the type of care to be offered at the facility would be different, and thus they were not really competing services.

- One large case study grantee increased the size of its transitional care unit from 8 beds (proposed) to 20 for more cost-effective staffing.

- The majority of case study grantees attributed positive financial effects to their projects. All grantees that implemented skilled nursing units did so by converting acute care beds, thus increasing facility occupancy rates. One grantee noted that its unit was making about $100,000 more per year for the hospital than the same space when used for acute care beds. One grantee said the grant had helped the hospital avert closure as it helped maintain the transitional care facility and start new projects.

- Implementation of these services often implied opening distinct patient units at the hospital. When extensive renovation or new construction was required, total implementation costs often exceeded the grant award and made supplementary financing necessary. Two grantees said the grants did not cover implementation costs; one said the hospital had to pay most of the construction costs.

INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	2
Grantees Implementing	5 (3.8%)	6 (3.1%)
Implementation Rate	NA	50%
Average Implementing Time (Months)	15	23
Number of Patients per Month	7	34*
Financially Self-Supporting at Grant End	40%	100%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems After Implementation

One grantee reported staff anxiety about working with mentally ill patients once the service was introduced. The hospital had to train its staff to work with these patients.

Achieving Success

Grantees recommended doing feasibility studies to determine the most economical program size and staffing specifications, and having a project coordinator to organize planning and implementation.

Points to Consider

- Four of the 1990 grantees implemented combined mental health and substance abuse programs that were financially self-supporting by grant's end.

- One grantee implemented a psychiatric clinic by converting 7 beds from an existing 20-bed chemical dependency unit. The hospital staffed both programs jointly for greater efficiency.

INPATIENT SURGERY

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	5
Grantees Implementing	0	5 (2.6%)
Implementation Rate	NA	100%
Average Implementing Time (Months)	NA	NA
Number of Patients per Month	NA	NA
Financially Self-Supporting at Grant End	NA	NA

NOTES: NA = not available.

Lessons from Case Study Grantees

Problems During Implementation

One case study grantee said planning took longer than expected.

Problems After Implementation

The surgeon recruited by one grantee proved unreliable, which caused physicians to refer patients to other surgeons. When the recruited surgeon quit, the grantee replaced the surgeon with an obstetrician who did general surgery. Utilization of the service was low in one case, as the community appeared unaware of its recent availability.

Achieving Success

Grantees recommended having a project coordinator to coordinate with surgeons, the director of nursing and other hospital staff, to schedule surgical suites, and to manage the program. They also suggested paying certified registered nurse anesthetists and registered nurses for assistance with surgeon recruitment and offering the surgeon a salary guarantee.

Maintaining Service

Promotion of the service was vital to start-up success. Meetings with local physicians made them more comfortable with changing established referral patterns while publicity (for example, newspaper ads featuring "profiles" of surgical staff or services) enhanced community awareness of service availability.

Points to Consider

- No information is available on the likelihood of financial self-support by grant's end for these services.

- One case study grantee used its funds to design and build a new surgical suite; another upgraded an existing suite, and one grantee had hospital staff do the construction work required in order to save money.

VENTILATOR UNITS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	2
Grantees Implementing	2 (1.5%)	0%
Implementation Rate	NA	0%
Average Implementing Time (Months)	17	n.a.
Number of Patients per Month	4	n.a.
Financially Self-Supporting at Grant End	50%	n.a.

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

An inability to obtain state agreement to reimburse the grantee for the service precluded one grantee from implementing the goal after preparing a room, buying equipment, and training staff (see Chapter 6, Case Study 9).

Problems After Implementation

Hospitals found that utilization was low once the service had been implemented, and one of the two programs implemented was not self-supporting by grant's end.

Achieving Success

We recommend doing feasibility studies to determine the likelihood of getting reimbursed before implementing the project.

ASSISTED LIVING

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	5
Grantees Implementing	0	0
Implementation Rate	NA	0
Average Implementing Time (Months)	n.a.	n.a.
Number of Patients per Month	n.a.	n.a.
Financially Self-Supporting at Grant End	n.a.	n.a.

NOTES: NA = not available.
n.a. = not applicable.

Lessons from Case Study Grantees

Problems During Implementation

Two case study grantees dropped the goal after feasibility studies showed the project to be too much of a financial commitment for the hospital, and one grantee had to drop the goal because of the community's opposition to having the facility in town. The hospital continues to look for a new site and hopes to implement this as a joint venture.

COMMUNITY AND PATIENT EDUCATION

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	17
Grantees Implementing	39 (29.5%)	61 (31.4%)
Implementation Rate	NA	76%
Average Implementing Time (Months)	17	14
Number of Patients per Month	654	127*
Financially Self-Supporting at Grant End	20%	28%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Points to Consider

- The majority of the programs were not financially self-supporting by grant's end.
- Programs implemented included screening services, health fairs, quarterly newsletters, and seminars. Grantees believed these services improved the community's health status, improved the visibility of their institutions, and maintained or expanded their market share.

WELLNESS AND FITNESS PROGRAMS

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	11
Grantees Implementing	18 (13.6%)	23 (11.9%)
Implementation Rate	NA	55%
Average Implementing Time (Months)	21	15
Number of Patients per Month	55	50*
Financially Self-Supporting at Grant End	61%	44%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One grantee wanted to implement a wellness program by offering these services at one or more of the local fitness centers. The hospital had to drop its project because the fitness centers were not interested in adding a health component to their fitness programs.

Points to Consider

- Half of the programs were not financially self-supporting by grant's end.
- Because of the hospitals' inability to cover costs, 12 percent of the programs implemented were slated for termination once the grants ended.

- Some grantees implemented fitness and wellness programs by expanding their cardiac rehabilitation programs and sharing staff. One grantee charged membership fees to cover the costs of the fitness component. Another grantee with a cardiac rehabilitation project hired a registered nurse to do health assessments, screening, and referrals in counties without doctors. The expanded focus was believed to improve public relations and the hospital's image in the community.

LIFELINE™ SERVICES

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	3
Grantees Implementing	NA	15 (7.7%)
Implementation Rate	NA	67%
Average Implementing Time (Months)	NA	25
Number of Patients per Month	NA	16*
Financially Self-Supporting at Grant End	NA	46%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One grantee said the equipment was more costly than expected. Another grantee found that achieving its proposed goal (in terms of number of units placed in the community) took longer than expected: (1) turnover in program management slowed program growth by detracting from marketing and service promotion and publicity; and (2) some patients in need could not afford to enroll in the program. The grantee overcame these early problems by soliciting donations from the community and publicizing the availability of the units.

Achieving Success

Coordination with other providers is a key to successful implementation.

Points to Consider

- The majority of programs were not financially self-supporting by grant's end.
- A Lifeline™ unit is a device worn by persons (for example, the frail, elderly living alone) that can be used to call for help.

HOME HEALTH AND HOSPICE SERVICES

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	14
Grantees Implementing	27 (20.5%)	34 (17.5%)
Implementation Rate	NA	50%
Average Implementing Time (Months)	20	16
Number of Patients per Month	443	461*
Financially Self-Supporting at Grant End	89%	90%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One grantee dropped the goal to avoid competing with a group of local physicians who implemented home health services. Another dropped its goal of implementing a hospice program (after 2 years of planning) because it realized that recruiting two family practitioners was a more urgent need in the area.

After an unsuccessful attempt to implement the goal on its own, one grantee hired a consultant to help set up the program to comply with Medicare home health regulations. Difficulties recruiting registered nurses delayed implementation of both home health and hospice programs for some grantees.

Problems After Implementation

One hospice program had difficulty getting nursing homes to participate in its program beacuse the nursing homes considered Medicaid reimbursement to be too low.

Achieving Success

Grantees recommended doing needs-assessment and feasibility studies to prepare for implementation, having a project coordinator to network with other providers and hospital staff, and using consultants to help prepare for Medicare certification.

Points to Consider

- Some grantees implemented home health programs with county health departments or other hospitals and nursing homes--sharing recruitment, staff training, and operating costs. One case study grantee implemented hospice services in a consortium with other area hospitals and nursing homes.

- Some grantees were very successful with their home health programs: these were Medicare certified, grew rapidly to as many as 2,000 visits per month, and generated net revenue for the hospitals.

- Case study grantees commented that the grants did not cover all implementation costs for their hospice and home health projects. Some grantees used trained volunteers for bereavement support groups and got donations from the community for constructing or renovating hospice units.

SOCIAL SERVICES AND OUTREACH

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	29
Grantees Implementing	12 (9.1%)	37 (19.1%)
Implementation Rate	NA	72%
Average Implementing Time (Months)	26	19
Number of Patients per Month	60	15*
Financially Self-Supporting at Grant End	67%	45%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One grantee could not find an affordable case management software package. The only one the hospital found also required a mainframe computer.

Problems After Implementation

One grantee had difficulty keeping track of expenditures for its case management program. This became an issue when the hospital began considering district expansion and, to prevent staff burnout from the increased caseload, the administrator had to document the cost-effectiveness of the program and justify hiring an assistant case manager.

Achieving Success

Coordination with other providers was an important strategy for implementing and maintaining the service.

Points to Consider

- About half of the programs implemented were financially self-supporting by grant's end.

- Social service projects included discharge planning, case management, and utilization review.

- Two case study grantees added case management and/or discharge planning as services for their skilled nursing units. One grantee hired a social worker for case management and trained a registered nurse for discharge planning. The social worker also marketed the facility to other area hospitals, and the grantee reported getting referrals. The other grantee set up a council of local providers, which met to discuss service needs and services available.

- Two case study grantees attributed declines in their average patient length of stay and number of readmissions to implementing case management services. One grantee commented that this had helped the hospital by improving its finances while preserving needed services.

- One case study grantee attributed to case management an improvement in the quality of care provided to patients because its two caseworkers verified whether patients had received the services ordered by their physicians. See Case-Study 1 in Chapter 6.

ADULT DAY CARE

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	7
Grantees Implementing	7 (5.3%)	5 (2.6%)
Implementation Rate	NA	43%
Average Implementing Time (Months)	25	11
Number of Patients per Month	15	83*
Financially Self-Supporting at Grant End	43%	50%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One case study grantee reported that space constraints and construction delays had impeded program implementation during the grant period. Another dropped the goal because it had trouble finding a site for its program.

Problems After Implementation

One grantee could not get Medicaid certification because its bathroom was too small. The hospital, however, could not finance major construction. In addition, many grantees found the services were not utilized much once implemented.

Achieving Success

We recommend feasibility studies to assess the program's likelihood of getting Medicaid certification and needs assessments to ensure sufficient patient volume.

Points to Consider

- The majority of the programs were not financially self-supporting by grant's end.

- Because of the hospitals' inability to cover program costs, two of the adult day care programs implemented by 1990 grantees were slated for termination once their grants ended. In addition, one case study grantee attributed low utilization to lack of Medicaid certification and inadequate transportation services for the program.

ROUTINE MEDICAL TRANSPORTATION

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	24
Grantees Implementing	10 (7.6%)	26 (13.4%)
Implementation Rate	NA	67%
Average Implementing Time (Months)	15	18
Number of Patients per Month	83	15*
Financially Self-Supporting at Grant End	20%	14%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

Some grantees reported that the need to purchase vehicles and/or equipment (such as wheelchair lifts and electric steps) delayed implementation. In addition, one grantee with too many project goals had to drop nonemergency transportation from its plan.

Problems After Implementation

Liability for volunteer drivers emerged as an issue: one grantee resolved the problem by purchasing liability insurance.

Achieving Success

Grantees noted several strategies that were important to their success, including appointing a coordinator during the planning and implementation process and persuading local car dealers to donate vans to the program. Grant funds were then used to equip the vans with lift gates and radio equipment.

Maintaining Service

To keep the service going after implementation, project directors can solicit donations from service users. Appointing a coordinator to schedule services can also keep the system functioning smoothly.

Points to Consider

- Few programs were financially self-supporting at grant end.
- Some grantees said that routine medical transportation services not only improved overall access to health care in their community but also helped physicians operate more efficiently because fewer patients missed appointments.
- Nonemergency transportation can support a variety of services, including outpatient projects (like cardiac rehabilitation or mental health programs), referrals from home health programs, and day trips for nursing home and adult day care patients.
- Volunteer drivers can be used to provide service, but liability insurance for these drivers must be considered.
- Although no case study grantees attributed direct financial effects to the program, one said that the service saved the hospital money by reducing ambulance calls for routine medical transportation. The service also generated indirect revenues by improving community access to the hospital and increasing patient volume.

EMERGENCY MEDICAL TRANSPORTATION

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	10
Grantees Implementing	10 (7.6%)	8 (4.1%)
Implementation Rate	NA	40%
Average Implementing Time (Months)	20	19
Number of Patients per Month	80	77*
Financially Self-Supporting at Grant End	70%	66%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One 1990 grantee tried to upgrade its ambulance service to paramedic level. It had 12 emergency medical technicians training for the paramedic service, but only 6 completed the training. The hospital was never able to get the eight qualified technicians it needed to get licensed. Eventually, the grantee had to sell its ambulance service to a private company, and some of its paramedics left in order to keep their licenses. One grantee that trained emergency medical technicians found many of those trained went on to work in other services.

Maintaining Service

Providing training and stipends for volunteer emergency medical technicians in order to increase retention proved helpful in maintaining the service.

Points to Consider

- Some grantees used grant funds to replace old ambulances or install radio equipment (including a radio tower). One grantee used funds to provide stipends for volunteer emergency medical technicians, to buy training equipment (including a TV, VCR, training tapes, and mannequins), and to send nurses and technicians to symposia. Some grantees introduced paramedic training at the local community college. Several rescue squads benefited from the opportunity to train and upgrade their service to advanced life support.

- Few case study grantees attributed significant financial effects for the hospital to their projects, although one hospital noted the grant had helped its finances indirectly by paying for necessary emergency medical service improvements. Another grantee that was expanding its service into new areas reported an increase in its admission rate because of the service.

MAMMOGRAPHY

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	6
Grantees Implementing	15 (11.4%)	10 (5.2%)
Implementation Rate	NA	50%
Average Implementing Time (Months)	26	16
Number of Patients per Month	70	23*
Financially Self-Supporting at Grant End	93%	86%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Problems During Implementation

One grantee dropped this goal in favor of getting a regular X-ray machine, which would serve more patients.

DIAGNOSTIC SERVICES (OTHER THAN MAMMOGRAPHY)

Grantee Statistics

	1989 Grantees	1990 Grantees
Grantees Proposing	NA	5
Grantees Implementing	NA	37 (19.1%)
Implementation Rate	NA	80%
Average Implementing Time (Months)	NA	19
Number of Patients per Month	NA	30*
Financially Self-Supporting at Grant End	NA	100%

NOTES: NA = not available.
* = median.

Lessons from Case Study Grantees

Points to Consider

- Most of the 1990 grantees implementing diagnostic services were small hospitals (containing fewer than 50 beds).
- All diagnostic services implemented were financially self-supporting by grant's end.
- One grantee purchased a portable X-ray machine, noticeably increasing volume of procedures; one purchased a blood analyzer. Lab results were available much sooner than from the outside lab previously used, in some cases allowing treatment to start sooner and lengths of stay to be reduced.

APPENDIX B

BIBLIOGRAPHY AND GENERAL RESOURCES

This appendix provides a bibliography of materials that may help rural hospitals as they assess changes they would like to make. First, we describe publications about the Rural Health Care Transition Grant Program and the Essential Access Community Hospital (EACH) Program. Second, we list publications by type of project: initiating new services, recruiting physicians, modifying management, improving quality of care or training staff, or starting consortia. The next section describes publications of general interest. Many of the publications can be purchased from only a few sources--such as the American Hospital Association (AHA), the National Rural Health Association (NRHA), and the U.S. Government Printing Office (GPO). Addresses for these and other organizations and sources of technical assistance are provided starting on page 124.

THE GRANT PROGRAM AND THE EACH PROGRAM

Cheh, Valerie, and Judith Wooldridge. *The Final Evaluation Report on the 1989 Grant Program for Rural Health Care Transition: Send Us More Doctors Please.* Report submitted to the Health Care Financing Administration. Princeton, NJ: Mathematica Policy Research, Inc., 1993.

> This 208-page report presents the findings of an evaluation of the effects of the Rural Health Care Transition grants on the financial and managerial performance of 1989 grantee hospitals. Using grantee reports and case study data, the report describes the projects implemented and whether these projects were utilized and financially self-supporting. A trend analysis of impacts on hospital use, finances, and management is included. A copy of the report (PR93-57) can be purchased for $18.60 ($16.10 plus $2.50 shipping and handling) from Mathematica Policy Research, Inc. A 13-page executive summary is available for $1.50. (Orders must be prepaid.)

Felt, Suzanne, and George Wright. *Developing Rural Health Networks Under the EACH/RPCH Program: Interim Report of the Evaluation of the Essential Access Community Hospital/Rural Primary Care Hospital Program.* Report submitted to the Health Care Financing Administration. Princeton, NJ: Mathematica Policy Research, Inc., September 1993.

> This 155-page report documents the initial development of the EACH program between October 1991 and December 1992. The information presented is based on three major data sources: (1) background information and progress reports from the providers involved in the program; (2) secondary data from

computerized files; and, (3) site visits by evaluation team members to state agencies and hospitals. A copy of the report (PR93-41) can be purchased for $13.35 ($10.85 plus $2.50 shipping and handling) from Mathematica Policy Research, Inc. (Orders must be prepaid.)

Wooldridge, Judith, Valerie Cheh, Nancy Holden, Lorenzo Moreno, and Marisa Giggie. *The Final Evaluation Report on the 1990 Grant Program for Rural Health Care Transition (Draft).* Report submitted to the Health Care Financing Administration. Princeton, NJ: Mathematica Policy Research, Inc., June 1994.

This 210-page report evaluates the impacts of grant-funded projects on access to and quality of health care services, and on the management and finances of 1990 grantee hospitals. A copy of the report can be purchased for $19.70 ($17.20 plus $2.50 shipping and handling) from Mathematica Policy Research, Inc. (Orders must be prepaid.)

PROJECT-SPECIFIC PUBLICATIONS

Outpatient and Emergency Services

Office of Rural Health Policy, U.S. Department of Health and Human Services. *Rural Mental Health and Substance Abuse Resources Directory 1993.* Washington, DC: Health Resources and Services Administration, Public Health Service, DHHS, 1993.

Individual copies may be obtained for $5 from the National Rural Health Association.

National Rural Health Association. *Success and Failure: A Study of Rural Emergency Medical Services.* Kansas City, MO: NRHA, 1990.

This publication presents the findings of a study of Emergency Medical Services (EMS) in rural areas of three states. Identifies common characteristics in the most successful systems and describes problems in providing EMS services in rural areas. Includes an action plan based on the study's results. Can be purchased for $5 from the NRHA.

Partners in Caregiving: The Dementia Services Program. *Information Packet.* Winston-Salem, NC: 1994.

This packet provides information about adult day care programs. It is available free of charge from the Partners in Caregiving Program.

Office of Technology Assessment. *Rural Emergency Medical Services: Special Report.* Washington, DC: Congress of the United States.

This 97-page report describes emergency medical services and related rural health services. Discusses federal aid for rural health services. This report is out of print and currently unavailable from the U.S. Government Printing Office

National Clearinghouse for Primary Care Information. *Development and Management of Ambulatory Care Programs: An Annotated Bibliography.* Rockville, MD: NCPCI, December 1993.

This 148-page annotated bibliography covers a variety of subjects. Compiled to assist health care professionals working in Bureau of Primary Health Care-supported projects in locating and obtaining relevant sources. This document can be obtained free of charge from the National Clearinghouse for Primary Care Information.

Rural Health Clinic Services Act: A Guidebook. 1991.

This guidebook is available from the Texas Center for Rural Health Initiatives.

Rural Health Clinic Services Act: Public Law 95-210.

This descriptive publication is available from the NRHA.

Inpatient Services

Swing Bed Planning Guide for Rural Hospitals, Revised 1993 Edition. Edited by Sarah A. Grim. Chicago: American Hospital Publishing, Inc., 1993.

This 192-page book provides guidance on implementing and operating swing beds for 50- to 99-bed rural hospitals, as well as hospitals with fewer than 50 beds. The book describes the historical and policy contexts of swing beds; federal, state, and local requirements (including definitions of eligibility); strategic

planning, reimbursement, and accounting systems; and quality of care. The book can be purchased from the AHA for $40 (members) and $50 (nonmembers).

Other Projects

Physician Recruitment

Academic Initiatives to Address Physician Supply in Rural Areas of the United States: A Compendium. Washington, DC: Association of American Medical Colleges, 1991.

This publication is available from the American Association of Medical Colleges.

Bibliographic Listing of Rural Health Professions Educational Strategies: Study of Models to Meet Rural Health Care Needs Through Mobilization of Health Professions Education and Services Resources. Kalamazoo, MI: Kalamazoo Center for Medical Studies, 1990.

This compendium was produced as part of a study of models to meet rural health care needs through mobilization of health professions and education services resources. The publication has two sections: (1) a list of current curricular programs for rural health professions; and (2) a list of articles on rural health education and health professional issues. Available from the NRHA for $8.

Hospital Research and Educational Trust. *Increasing Rural Health Personnel: Community-Based Strategies for Recruitment and Retention.* Chicago: HRET, 1992.

Recruiting and retaining the human resources--doctors, nurses, and allied health professionals--to provide care has always been difficult and often expensive for rural communities. This 50-page monograph discusses some of the reasons why recruitment in these areas is difficult and offers some examples of how creative thinking has led to successful recruitment. The publication can be purchased from the AHA for $20 (members) and $35 (nonmembers).

The Center for Rural Health. *9 Steps to Successful Physician Recruitment and Retention*. Grand Forks, ND: CRH, 1991.

This nine-page booklet can be obtained from CRH.

Bonds, Roger G., and Kimberly A. Pullman. *Physician Recruitment & Retention: Practical Techniques for Exceptional Results.* Chicago: American Hospital Publishing, Inc., 1991.

This 224-page book is a comprehensive guide to planning and implementing an effective physician recruitment program. The first part concentrates on the planning phase and provides the reader with an understanding of the principles of recruitment, what resources will be needed, how to decide between in-house and outside recruitment, what the legal issues are, and how to set up a physician work force plan that will provide the best staff mix. The second half of the book presents a blueprint for action--getting organized, identifying and screening candidates, planning the recruitment visit, and closing the deal. A final chapter describes how successful recruitment should build on long-term retention. The book can be purchased from the AHA for $35 (members) and $45 (nonmembers).

Rural Nursing. Edited by Angeline Bushy. Newbury Park, CA:

Projects with Management Objectives

Engineering a Hospital Turnaround: Proven Strategies for Reinvigorating Financial and Operating Performance. Edited by Richard A. Baehr for Ernst & Young. Chicago: American Hospital Publishing, Inc., 1993.

This 208-page book is intended to help hospital managers improve and strengthen the financial and operational performance of their facilities to become lower-cost, higher-quality, and more-integrated providers of care. It can be purchased from the AHA for $36 (members) and $45 (nonmembers).

Hastings, Malcolm R. *Cost Management Strategies for Smaller Hospitals.* Chicago: American Hospital Association, 1993.

This 124-page book describes strategies to establish cost-control measures that will improve financial viability. The relationship between the cost-containment process and capital planning is examined. Specific techniques are presented for utilizing budgets as a monitoring tool and for creating a flexible departmental budget that analyzes variances and links strategic and financial management through capital planning. It can be purchased from the AHA for $36 (members) and $45 (nonmembers).

Krohm, Gregory C., Mary P. Merrill, and Alan B. Talarczyk. *Investment Program Management for Health Care Institutions.* Chicago: American Hospital Publishing, Inc., 1990.

This publication examines the prerequisites for establishing an investment program, assessing institutional needs and preferences, and writing an investment policy that takes into consideration an institution's mission, financial resources, cash-flow needs, investment policy, and attitudes toward risk.

Mason, Scott, Hindy Shaman, and Monte Dube. *Diversification and Conversion Strategies for Rural Hospitals.* Chicago: Hospital Research and Educational Trust, 1989.

This publication defines and illustrates diversification and conversion strategies. It provides guidelines and a logical, clearly written examination of diversification and conversion strategies in a changing health care environment. It can be purchased from the AHA for $20 (members) and $35 (nonmembers).

Financing Rural Health Care. Edited by LaVonne Straub and Norman Walzer. New York: Praeger, 1988.

This 230-page book examines the economics of health care delivery, financial management methods, health policy trends, and rural health care trends.

Roberts, Carolyn, and Eugene Beck. *Marketing in Small and Rural Hospitals.* Chicago: American Hospital Publishing, Inc., 1989.

This 351-page book describes a comprehensive marketing approach tailored to the unique needs of small and rural hospitals. Chapters cover the rural environment, the relationship between planning and marketing, market research, how to work with a consultant, budgeting, and four principles of marketing. A chapter on case studies illustrates the marketing principles discussed in the text. It can be purchased from the AHA for $28 (members) and $35 (nonmembers).

Amundson, Bruce, and William Elder. *Prelude to Strategic Planning: Making Your Organization and Community Fit for Success.* Chicago: American Hospital Association, 1989.

Written in straightforward language for community health care providers, this publication explains six critical elements that are needed prior to strategic planning and describes ways to build bridges between health care providers and

the community. This 49-page monograph will help board members, trustees, professional staff, employees, and the community work together to ensure successful development, implementation, and evaluation of strategic plans. It can be purchased from the AHA for $20 (members) and $35 (nonmembers).

Center for Rural Health. *7 Steps to Strategic Planning for Rural Health: Working Together for Rural Action*. Grand Forks, ND: CRH, 1990.

This 19-page booklet looks at strategic planning for rural health facilities and services, taking a holistic and board-sector approach. It draws upon the recommendations and experiences of the Affordable Rural Coalitions for Health, the American Hospital Association Strategic Planning Guide, and other guides. It can be obtained from CRH.

Jennings, Ryan Federa & Company. *Strategic Planning Workbook.* Chicago: Hospital Research and Educational Trust, American Hospital Association, 1989.

In an easy-to-use, spiral-bound format, this 105-page workbook presents a 10-step strategic planning process. By using this publication, health care providers and their communities will be able to reduce reliance on outside consultants and develop a comprehensive, community-based strategic plan that includes mechanisms for implementation and evaluation. It can be purchased from the AHA for $35 (members) and $50 (nonmembers).

Staff Training and Quality of Care Projects

Gaucher, Ellen, and Richard Coffey. *Total Quality in Health Care: From Theory to Practice.* San Francisco: Jossey-Bass, 1993.

Provides practical guidance for implementing Total Quality Management (TQM) in health care institutions.

Melum, Mara Minerva, and Marie Kuchuris Sinioris. *Total Quality Management: The Health Care Pioneers.* Chicago: American Hospital Publishing, Inc., 1992.

This book is an executive's guide to the principles of Total Quality Management as exemplified by the experiences and achievements of health care leaders. The authors collaborated with almost 40 health care innovators who contributed case studies or participated in personal interviews. This publication can be purchased from the AHA for $55 (members) and $69 (nonmembers).

Lord, Jonathan, and Kathleen Ciccone. *IQA2: Continuous Performance Improvement Through Integrated Quality Assessment.* Hospital Association of New York State. Chicago: American Hospital Publishing, Inc., 1992.

Building on the original 1989 IQA model, new Joint Commission standards, and Continuous Quality Improvement theories, this 260-page book presents a model for integrating hospitalwide and medical and nursing staff quality assessment activities into a patient-focused system for continuous improvement. Chapters contain ready-to-use or ready-to-adapt forms and worksheets, as well as illustrations of techniques. This publication can be purchased from the AHA for $39.95 (members) and $49.95 (nonmembers).

Quality Management in Ambulatory Care. Edited by Patrice Spath. Chicago: American Hospital Publishing, Inc., 1992.

This 222-page book describes how 12 different ambulatory health care organizations have taken the theory of quality management and transformed it into workable, effective programs. The text, directed to quality managers, physicians, and directors of nursing in ambulatory care centers, describes how these organizations, ranging from primary care clinics to hospital-based outpatient centers, are defining, measuring, and achieving quality. This publication can be purchased from the AHA for $39.95 (members) and $49.95 (nonmembers).

Leebov, Wendy, and Clara Jean Ersoz. *The Health Care Manager's Guide to Continuous Quality Improvement.* Chicago: American Hospital Publishing, Inc., 1991.

This 233-page book is a comprehensive guide to the nuts and bolts of Continuous Quality Improvement (CQI). The text provides the reader with an understanding of the CQI concept, an eight-step customer-driven model for implementing CQI, and the tools and techniques that can make implementation a reality. It can be purchased from the AHA for $39.95 (members) and $49.95 (nonmembers).

Begun, James W., and Ronald C. Lippincott. *Strategic Adaptation in the Health Professions: Meeting the Challenges of Change.* San Francisco: Jossey-Bass, 1993.

Specific advice and strategies are offered to help the reader adapt to new market demands. This 270-page book can be purchased for $35.95 by calling 415-433-1767.

Consortia

The Robert Wood Johnson Foundation. *Rural Health Challenges in the 1990s: Strategies from the Hospital-Based Rural Health Care Program.* Edited by Victoria D. Weisfield. Princeton, NJ: RWJ, 1993.

This 175-page manual provides information about some of the consortium projects initiated under the Robert Wood Johnson Foundation's Hospital-Based Rural Health Care Program. The publication describes program highlights and gives useful information on other related efforts in the rural health care field. It is divided into six broad areas: (1) development of consortia; (2) organization of services; (3) provider recruitment and retention; (4) quality of care; (5) financial management; and (6) the foundation's program-related investments. The manual can be purchased from the Robert Wood Johnson Foundation, Route 1 and College Road East, P.O. Box 2316, Princeton, NJ 08543-2316 (Telephone: 609-452-8701).

Working Together to Improve Health Services Delivery: Observations on Collaboration by Rural Hospitals and Health Care Systems. Chicago: American Hospital Publishing, Inc., 1992.

This monograph contributes a practical point of view to the national debate about health care reform, incorporating the concerns of rural hospitals and health care systems. Collaboration between rural hospitals and health care systems offers a useful model for (1) ensuring access, and (2) promoting efficiency in a health delivery system, two key principles to guide the development of a health care reform strategy. The publication can be purchased from the AHA for $10.95 (members) and $15.95 (nonmembers).Sage Publications, Inc., 1991.

PUBLICATIONS OF GENERAL INTEREST

American Association of Retired Persons. *A Guide to the Development of Health Promotion Programs for Minority Elders.* Washington, DC: AARP, April 1993.

This guide provides information to assist with design, development, implementation, and evaluation of health promotion programs for minority and low-income elders. Contains an appendix listing other national organizations to contact about health promotion for older minority adults. Copies can be obtained from the American Association of Retired Persons.

The National Association of Insurance Commissions and the Health Care Financing Administration, U.S. Department of Health and Human Services. *1993 Guide to Health Insurance for People with Medicare.* Washington, DC: DHHS, 1993.

The guide describes the extent of Medicare coverage, types of private health insurance, tips on shopping for private health insurance, and 10 standard medigap insurance plans. Lists the addresses and telephone numbers of all state agencies on aging and state insurance departments. Copies can be purchased from the U.S. Government Printing Office.

Health Care Financing Administration, U.S. Department of Health and Human Services. *The Medicare Handbook.* Washington, DC: DHHS, 1993.

The handbook provides a detailed and current explanation of the Medicare program. Available from Social Security Administration offices or by writing to Medicare Publications, Health Care Financing Administration.

Bauer, Jeff, Kimball Miller, and Eileen Weis. *Plugging the Leaks in Health Care: Harnessing Economic Opportunity in Rural America*. Denver: Center for the New West, 1992.

This 204-page handbook uses concise, easy-to-understand language to tell civic leaders how they can take charge of planning and decision processes as communities assess their present and future health needs. The book provides information on the range and types of providers and medical facilities available. There are also sections spelling out the available choices on a wide variety of topics--including financing, networking, and recruiting and retaining physicians and other health care providers. The handbook is available for $19.95 from the Center for the New West, 600 World Trade Center, 1625 Broadway, Denver, CO 80202-4706.

Simmons, Louise Murphy. *Rural Health Services Funding: A Resource Guide.* Beltsville, MD: National Agricultural Library, December 1991.

The 34-page publication is free from the Rural Information Center Health Service.

Barker. *The Resource Book: Directory of Organizations, Associations, Self-Help Groups, and Hotlines for Mental Health and Human Services, Professionals and Their Clients.* Binghamton, NY: Haworth Press, 1987.

The book is available from Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904 (Telephone: 800-342-9678 or 607-772-5857).

National Rural Health Association. *The Rural Health Resources Directory 1994.* Kansas City, MO: NRHA, 1994.

This general directory lists individuals, organizations, and agencies involved in rural health issues. It is available from NRHA for $10.

Wellever, Anthony L., and Steven Rosenberg. *Alternative Models for Organizing and Delivering Health Care Services in Rural Areas: Volume 2. State-Sponsored Alternative Models: The State Government Perspective.* Kansas City, MO: National Rural Hospital Association, 1994.

This 68-page monograph is part of a six-volume collection. It presents the findings of a 1992 study of government-sponsored service delivery models in nine states. A copy of the publication can be purchased from the NRHA for $25 (members) and $30 (nonmembers). The collection of monographs is also available for $135 (members) and $150 (nonmembers).

Carmody, Jean, and DonnaRae Castillo. *Annotated Bibliography: Rural Health Services Research, 1968-1990.* Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services, 1991.

The bibliography is available from National Technical Information Services, Springfield, VA.

Bureau of Primary Health Care-Supported Primary Care Centers: Directory. April 1993.

The directory provides information on nine federal grant programs administered by the Bureau of Primary Health Care. The grant programs support primary health services for medically underserved, disadvantaged, high-risk, and hard-to-reach populations in the United States and its territories. Free copies can be obtained from the National Clearinghouse for Primary Care Information.

Walker, Mary, and Sara Breuer. *Community Assessment, Health Care, and You: A Handbook for the Concerned Rural Texan.* Austin, Texas: Texas Rural Health Field Services Program, January 1992.

This 55-page publication describes the four steps in the community assessment process: (1) preparation, (2) organization, (3) identification of problems and goals, and (4) development of a community action plan.

Hewitt, Maria. *Defining "Rural" Areas: Impact on Health Care Policy and Research.* Washington, DC: Office of Technology Assessment, Congress of the United States, July 1989.

This 56-page report discusses the U.S. Census's differentiation between rural and urban areas, diversity within rural areas, availability of vital and health statistics for nonmetropolitan areas, and health programs developed for specific rural areas.

Office of Technology Assessment. *Health Care in Rural America.* Washington, DC: OTA, Congress of the United States, September 1990.

This 540-page report presents the findings of a study prepared by OTA at the request of the Congress. The study addressed the availability of health services in rural communities, problems facing rural providers, and remedial strategies that might be influenced by federal policy. This publication provides an overview of rural populations and health programs, discusses the availability of rural health services and personnel, and includes two case studies. It is available for $22 from the U.S. Government Printing Office.

Health Care Needs, Resources, and Access in Rural America. A report to the National Electric Cooperative Association and Prudential Insurance Company of America. Washington, DC: National Rural Electric Cooperative Association, November 1989.

This 65-page report discusses rural economies, the status of rural health care and available resources, and methods for improving rural health care, (for example, recruiting and retaining health professionals, developing preventive services).

The University of Iowa. *Implementing Health Care Reform in Rural America: State and Community Roles.* Iowa City, IA: The University of Iowa, 1994.

This two-volume publication summarizes a 1993 conference for health care providers and policymakers. The first volume is a legislative compendium that

summarizes currently funded federal rural health legislation and pending federal legislative proposals as abstracted by the Congressional Research Service. The proceedings volume includes the full text of all presentations, together with summaries of panel discussions and question-and-answer sessions. The two volumes can be purchased for $60 by writing to the University of Iowa, Center for Conferences and Institutes, Division of Continuing Education, 249 Iowa Memorial Union, Iowa City, IO 52242-1317 (Telephone: 319-335-3231, FAX: 319-335-3533).

Shapiro, Isaac. *Laboring for Less: Working but Poor in Rural America.* Washington, DC: Center on Budget and Policy Priorities, October 1989.

This book profiles the working poor living outside metropolitan areas, including the type and extent of work among the nonmetropolitan poor and related poverty rates. It also examines factors related to the increase in working poor populations during the past decade.

Summer, Laura. *Limited Access: Health Care for the Rural Poor.* Washington, DC: Center on Budget and Policy Priorities, March 1991.

This 103-page publication discusses issues relevant to rural and urban residents, including the availability of health care providers in rural areas, health insurance, and federal health programs for low-income residents of rural areas.

McGuire, Catherine, Mary Walker, and Sara Breuer. *Options for Rural Hospitals: A Resource Manual.* Austin, TX: Health Care Options for Rural Communities, 1991.

This publication is available from the Texas Center for Rural Health Initiatives, P.O. Box 1708, Austin, TX 78767 (Telephone: 512-479-8891).

Porter, Kathryn. *Poverty in Rural America: A National Overview.* Washington, DC: Center on Budget and Policy Priorities, April 1989.

This 25-page report discusses recent trends in rural poverty, the extent of poverty in rural America, and the rural poor.

National Rural Health Association. *Rural Health Care Projects Funded by Foundations, 1990.* Rockville, MD: Office of Rural Health Policy, U.S. Department of Health and Human Services, 1990.

This publication lists projects funded by private sector organizations to support improving hospital survival, recruiting and retaining health professionals, developing coordinated systems of care, and managing care in rural areas. Can be purchased from the NRHA for $5.

National Rural Health Association. *Rural Health Research Compendium, 1989.* Kansas City, MO: NRHA, 1989.

This compendium lists ongoing research and studies in rural health completed since 1983. Entries include author's name, full citation, current status of work, financing organization, and availability of findings. Can be purchased from the NRHA for $5 (members) or $7.50 (nonmembers).

Foundation for Health Services Research and National Rural Health Association. *Rural Health Services Research Agenda.* Ann Arbor, MI: Health Administration Press, 1989.

This publication summarizes a 1987 conference sponsored by the NRHA and the Foundation for Health Services Research.

State Approaches to Solving Rural Health Problems: Workshop Summary. Kansas City, MO: National Rural Health Association, 1990.

This document was published by the NRHA but is currently out of print.

McCloskey, Amanda H., and John Luehrs. *State Initiatives to Improve Rural Health Care.* Washington, DC: National Governor's Association, 1990.

This 119-page publication describes a broad range of ongoing state programs and policies that are designed to improve access to rural health care. It discusses the structure and roles of state commissions and task forces on rural health, state offices of rural health, and includes a compendium of state rural health initiatives.

American Hospital Association. *Rural Hospital Closure: Management and Community Implications.* Chicago: Hospital Research and Educational Trust, American Hospital Association, 1989.

This publication includes information on rural hospital closures between 1980 and 1987 and discusses closure within the context of planning ongoing hospital or community health services. It includes a literature search and results of a survey

completed by administrators at closed hospitals. It can be purchased from the AHA for $15 (members) and $35 (nonmembers).

Prospective Payment Assessment Commission. *Rural Hospitals Under Medicare's Prospective Payment System.* Washington, DC: Congressional Budget Office, Congress of the United States, 1991.

This 125-page report examines changes in Medicare payment policies since the enactment of the prospective payment system. The negative financial impact on rural hospitals is discussed in depth.

U.S. General Accounting Office. *Rural Hospitals: Factors that Affect Risk of Closure: Report to Congressional Requesters.* Washington, DC: GAO, June 1990.

Rural Hospitals: State Policy Issues and Initiatives. 1989.

Available from the National Governor's Association.

Strategies and Environments of America's Small Rural Hospitals. Edited by John Seavey, David Berry, and Richard Bogue. Chicago: Hospital Research and Educational Trust, American Hospital Association, 1992.

This 325-page book investigates the interplay between environment and strategy, documenting rural hospitals' strategies in a variety of environments. It also includes 10 detailed case studies and discusses factors for successful adaptation. This publication is the result of a two-year project funded by the Pew Charitable Trusts. It can be ordered from the AHA for $24.95 (members) and $29.95 (nonmembers).

American Hospital Association. *Working from Within: Integrating Rural Health Care.* Chicago: Hospital Research and Educational Trust, AHA, 1993.

Through case studies and analysis, this 94-page publication describes how health care providers in some rural communities have integrated their efforts to create and maintain coordinated systems of high-quality, low-cost health care. The cases illustrate collaborative ventures characteristic of the concept of "community care networks," the integration of professional education with the clinical needs of communities, and programs that address the special needs of rural adolescents. The authors extract lessons from these communities and summarize their efforts to integrate and restructure their health care delivery systems. This

publication can be purchased from the AHA for $20 (members) and $35 (nonmembers).

SOURCES OF TECHNICAL ASSISTANCE AND INFORMATION

Federal Agencies

Office of Rural Health Policy

This federal office was established in 1987 and operates out of the Health Resources and Services Administration, U.S. Department of Health and Human Services. The office works with federal agencies, states, foundations, and private sector organizations to seek solutions to rural health care problems. It administers a grant program supporting the development and operation of state offices of rural health and a grant program supporting innovative outreach health care projects to rural communities. Address: Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, Parklawn Building, 14-22, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857 (Telephone: 301-443-0835).

Health Care Financing Administration

Address: 6325 Security Blvd., Baltimore, MD 21207 (Telephone: 410-966-3000).

U.S. Department of Health and Human Services

Address: 200 Independence Avenue, S.W., Washington, DC 20201 (Telephone: 202-690-7000).

U.S. Government Printing Office, Superintendent of Documents

Address: Mail Stop: SSOP, Washington, DC 20402-9328 (Telephone: 202-783-3238).

National Organizations

American Association of Retired Persons

Address: 601 East Street, N.W., Fifth Floor-B, Washington, DC 20049 (Telephone: 202-434-2200, Fax: 202-434-6474).

American Hospital Association (AHA)

Individuals and organizations can join the AHA mailing list and receive mailings on recent publications by American Hospital Publishing, Inc., free of charge. AHA membership is not required. Addresses: 50F Street, N.W., Suite 1100, Washington, DC 20001, or 840 North Lake Shore Drive, Chicago, IL 60611 (Telephone: 202-638-1100 or 800-242-2626).

AHCPR Publications Clearinghouse

Address: P.O. Box 8547, Silver Spring, MD 20907 (Telephone: 800-358-9295).

Association of American Medical Colleges

Address: 2450 N. Street, N.W., Washington, DC 20037 (Telephone: 202-828-0400).

The Center for Rural Health

Address: 501 North Columbia Road, Grand Forks, ND 58202 (Telephone: 701-777-3848).

Center on Rural Elderly

Address: 5245 Rockhill Road, Kansas City, MO 64110 (Telephone: 816-276-2181).

National Association for Rural Mental Health

Address: 337 E. Ferguson Avenue, P.O. Box 570, Wood River, IL 62095 (Telephone: 618-251-0589, Fax: 618-251-6246).

National Association of Community Health Centers

Address: 1330 New Hampshire Avenue, N.W., Suite 122, Washington, DC 20036 (Telephone: 202-659-8008).

National Association of Rural Alcohol and Drug Abuse

Address: Box 40, Tony, WI 54564-0040 (Telephone: 715-532-3363).

National Clearinghouse for Primary Care Information

Address: 8201 Greensboro Drive, Suite 600, McLean, VA 22102 (Telephone: 703-821-8955, extension 248).

National Council on the Aging, Inc. (NCOA)

The NCOA is a private, not-for-profit organization that serves as a national resource for information, training, technical assistance, advocacy, and research on aging issues. Address: 409 Third Street SW, Washington, DC 20024 (Telephone: 202-479-1200, Fax: 202-479-0735).

National Institute on Adult Daycare (NIAD)

The NIAD is a national organization sponsored by the National Council on the Aging, Inc. (NCOA). NIAD advocates public policy issues related to adult day care, acts as a community service to impaired adults and their families, and provides program information, technical assistance, and consultation on adult day care issues. For membership or technical assistance information, contact the NCOA (see above).

National Rural Health Association (NRHA)

The NRHA is a national nonprofit membership organization that is dedicated to improving the health and health care of rural Americans. Address: 301 East Armour Blvd., Suite 420, Kansas City, MO 64111 (Telephone: 816-756-3140, Fax: 816-756-3144).

National Rural Health Network

Address: 1800 Massachusetts Avenue, N.W., Washington, DC 20036 (Telephone: 202-857-4883).

National Rural Institute on Alcohol and Drug Abuse.

Address: School of Arts and Sciences, Outreach, University of Wisconsin, Eau Claire, WI 54702-4004 (Telephone: 715-836-2031).

Foundations

Information on national and local foundations can be found in *The Foundation Directory, 1994 edition.* Edited by Stan Olson. New York: Foundation Center, 1994.

Manuals identifying state-specific foundations can be found in local libraries.

Other Resources

Agricultural Library Forum

The Agricultural Library Forum (ALF) is the electronic bulletin board of the National Agricultural Library. The RIC/RICHS staff manages a regular conference on ALF. This conference includes the latest information on federal funding for rural health, state contacts for rural development, pending legislation, conferences on rural health, and relevant publications and research. To access ALF, one needs a computer, modem, and communications software. There is no subscription fee, but phone charges apply (Telephone: 301-504-5496, 301-504-5497, 301-504-6510, and 301-504-5111). ALF is also accessible through INTERNET. For help with this service, contact RIC/RICHS at 800-633-7701, Monday to Friday, 8:00 a.m. to 4:30 p.m., Eastern time.

Mathematica Policy Research, Inc.

Address: P.O. Box 2393, Princeton, NJ 08543-2393.

Partners in Caregiving: The Dementia Services Program

Address: Department of Psychiatry and Behavioral Medicine, Bowman Gray School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1082 (Telephone: 919-716-4941).

Rural Information Center Health Service (RICHS)

The Rural Information Center Health Service provides information and referral services on rural health issues. It is operated as part of the National Agricultural Library (NAL) as a joint project of the Office of Rural Health Policy, U.S. Department of Health and Human Services, and the NAL, U.S. Department of Agriculture. RICHS staff will respond to individual inquiries (requests for references on specific rural health projects or requests for information about

federal grant programs) with customized assistance. Staff will also refer users to organizations and experts in the field who can provide additional information and furnish bibliographies and selected publications of the Office of Rural Health Policy, the National Advisory Committee on Rural Health, and the RICHS publication series. This service is available through (1) the RICHS toll-free number (800-633-7701, available Monday to Friday, 8:00 a.m. to 4:30 p.m., Eastern time); (2) mail addressed to Rural Information Center, NAL, Room 304, 10301 Baltimore Blvd., Beltsville, MD 20705-2351; and (3) electronic mail (INTERNET: RIC@/NALUSDA.GOV).

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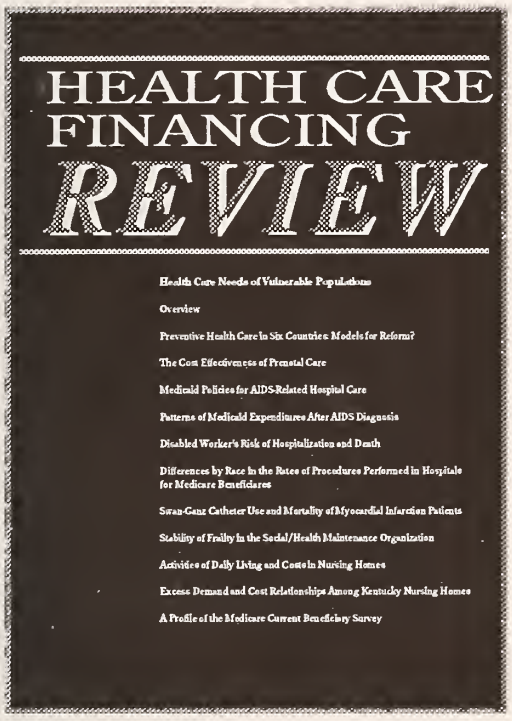

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